

RESTRICTED

THE SURGEON'S

Circular Letter

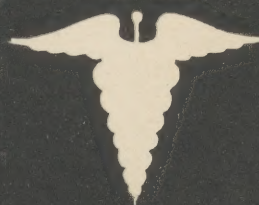
SEPT. 1951

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A FAR EAST
PERIODICAL



OF ARMY
MEDICAL SERVICES
INFORMATION

APO 500

MEDICAL SECTION • GHQ • FEC, SCAP AND UN
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African Air Force Sgt Dennis Collins donates blood, 406th Blood Bank in Tokyo.



American and Japanese technicians check blood samples, 406th serology laboratory.



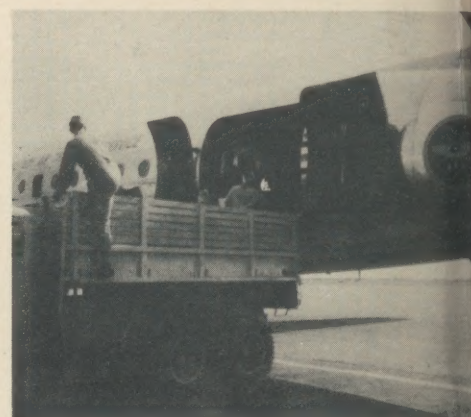
Labels on whole blood are checked by Sgt Benson before refrigerated storage.



Lt Dalium and Sgt McAuliffe prepare shipment of whole blood from 406th Blood Bank.



Japanese workmen load cases of blood on MATS Korean courier plane, Haneda.



Last case of blood goes aboard MATS plane. Flight will be in Korea within few hours.



Maj Lemm of 406th Blood Bank cross matches blood samples for local hospital.



Lt Col. M. Galloway administers whole blood to patient, Tokyo Army Hospital.



In Korea at 8209th MASH, blood is given to patient during exploratory operation.

On the cover

An Army leg splint is applied and plasma administered to an American infantryman wounded in the Kumhwa-Sangyang-Ni action late in September. All photographs are from US Army Signal Corps unless other indicated.

RESTRICTED

ADMINISTRATIVE

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ARMY MEDICAL PERSONNEL WIN OUTSTANDING NUMBER OF DECORATIONS IN KOREA

Office of the Surgeon General, Technical Information Office, DA, Washington 25, D.C.

A preliminary survey reveals that over 2,800 decorations have already been awarded to Army Medical Service personnel for service in the Korean campaign, Major General George E. Armstrong, Army Surgeon General, recently announced.

The total includes a posthumous award of the Medal of Honor to Private Richard C. Wilson, aid man with the 187th Airborne Infantry Regiment; 9 Distinguished Service Crosses; 2 Distinguished Service Medals; 149 Silver Stars; 28 Legion of Merit awards; 2 Distinguished Flying Crosses; 11 Soldier's Medals; 1,369 Bronze Star Medals; 9 Air Medals; 126 Commendation Ribbons and 1,110 Purple Hearts.

Eighty-five percent of the decorations were awarded to Army Medical Service enlisted men. In addition to the Medal of Honor these included 8 Distinguished Service Crosses; 122 Silver Stars; 8 Soldier's Medals; 1,080 Bronze Star Medals; 103 Commendation Ribbons; and 1,068 Purple Hearts.

Medical Service Corps officers serving as assistant

battalion surgeons, administrators, supply officers, or in similar capacities, received almost 10% of the total, including 20 Silver Stars, 7 Legion of Merit awards; 2 Distinguished Flying Crosses; 3 Soldier's Medals; 192 Bronze Stars; 1 Air Medal; 11 Commendation Ribbons and 36 Purple Hearts.

Medical Corps officers received 105 decorations, including 1 Distinguished Service Cross; 2 Distinguished Service Medals; 7 Silver Stars; 18 Legion of Merit awards; 59 Bronze Star medals; 8 Air Medals; 6 Commendation Ribbons and 4 Purple Hearts.

Sixteen dental officers were decorated. Awards included 1 Legion of Merit; 11 Bronze Star medals; 2 Commendation ribbons and 2 Purple Hearts. One Veterinary officer received the Bronze Star.

Awards to the Women's Corps of the Army Medical Service totaled 32, including 2 Legions of Merit; 26 Bronze Stars and 3 Commendation Ribbons to Army Nurse Corps officers, and 1 Commendation Ribbon to an officer of the Women's Medical Specialist Corps.

AWARD OF THE PURPLE HEART

The following extract of Change 4, AR 600-45, dated 23 August 1951, is published for the information of all concerned.

"For the purpose of considering an award of this decoration, a 'wound' is defined as an injury to any part of the body from an outside force or agent sustained while in action in the face of the armed ene-

my or as a result of a hostile act of such enemy. A physical lesion is not required provided the concussion or other form of injury received was directly due to enemy action and required treatment by a medical officer. Awards will not be made by reason of injuries due to frostbite or trenchfoot. Not more than one award of this decoration will be made for more than one wound or injury received at the same instant or from the same missile, force, explosion, or agent."

ARMY MEDICAL SERVICE OFFICER PERSONNEL REASSIGNMENTS



During recent weeks the personnel picture within the Surgeon General's Office, the Medical Section, GHQ FEC, and the Eighth Army has changed as a result of officer transfers in key positions. In addition to those described in the August issue of the SURGEON'S CIRCULAR

LETTER, the following transfers have been announced.

Lt. Colonel Ruby F. Bryant, ANC, will succeed Colonel Mary G. Phillips, ANC, as Chief of the Nursing Division, SGO, on 1 October. Col. Bryant will serve as Assistant Chief of the Division pending official assumption of her new duties.

Also within SGO, Colonel R. G. Prentiss, Jr., MC, has been named Executive Officer to succeed Colonel Thomas J. Hartford, MC, who has moved to Tripler Army Hospital as Commanding Officer. The office of Chief of Preventive Medicine Division has been assumed by Col. Tom F. Wayne, MC, who recently completed studies at the Harvard School of Public Health and the Army Med-

ical Service Graduate School.

At the Medical Section, GHQ FEC, Colonel Donald B. Peterson, MC, has arrived in Tokyo to relieve Colonel Albert J. Glass, MC, Neuropsychiatric Consultant to the Chief Surgeon. Col. Glass will return to Letterman Army Hospital as Chief, Psychiatric Branch, Neuropsychiatric Service.

Less recently, Colonel Harry E. Van Tuyl, VC, became Veterinary Consultant, GHQ FEC, having replaced the late Colonel Arvo T. Thompson, VC.

In Korea, Colonel Thomas N. Page, MC, has left IX Corps to become Surgeon, Eighth Army, replacing Colonel Chauncey E. Dovell, MC, who will go to the Army Field Forces, Ft. Monroe. Colonel John E. Taber, MC, former Chief of Medical Service at Fort Riley, was named IX Corps Surgeon.

Lt. Colonel Madeline Desmond, ANC, for many months Chief Nurse, Eighth Army, has returned to the United States for reassignment. She has been relieved by Major Ruby G. Bradley, ANC. Maj. Bradley was formerly Chief Nurse of the 171st Evacuation Hospital in Korea where she has served since the Inchon landing. During World War II, Maj. Bradley was a prisoner-of-war in the Philippines for three years.



CENTRAL MEDICAL LIBRARY

Announcement is made that a Central Medical Library has been established at the Tokyo Army Hospital for use of medical personnel throughout the Far East Command. At this time the library has over four thousand scientific books, three thousand volumes of bound journals and approximately fifty

thousand unbound journals. This material consists of the best of current literature in the fields of medicine and surgery, dentistry, veterinary medicine, nursing, and allied subjects.

It is the mission of the library to operate an inter-library and personal loan service. To provide the

best service possible, the library will add to its collection selected professional literature as it becomes available for procurement. It is planned to further develop the library to provide the ultimate in reference material for personal loan service.

All personnel of the medical services in the Far East Command are invited to avail themselves of this facility. The literature on hand is in the process of being cataloged and indexed. A card or letter addressed to the Librarian, Central Medical Library, Tokyo Army Hospital, APO 1052, for personal loan service is all that is required. Inter-library service with other service libraries is available upon request. The library works in close cooperation with the Army Medical Library of Washington, largest medical library in the world. Material from that great collection can, when available, be borrowed through our Central Medical Library.

MEDICAL UNITS ENTITLED TO BATTLE CREDITS



General Orders No. 190, GHQ FEC, have been published naming Army units which have been awarded battle participation credits. The following list of medical units has been extracted from G.O. 190 and does not attempt to include medical units which are an organic part of larger ground force units.

Credits begin on the respective dates shown after the unit designations for the UN Offensive (credit beginning on or after 16 September 1950) or for both the

UN Defensive and the UN Offensive (credit beginning on or before 15 September 1950). Campaigns are delineated below.

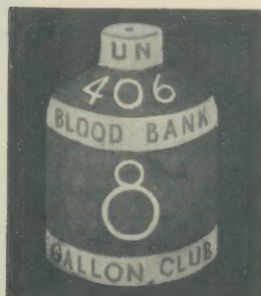
- a. Combat Zone. Territorial limits of Korea and adjacent waters.
- b. Time Limitation.
 - (1) UN Defensive: 27 Jun to 15 Sep 50, inclusive.
 - (2) UN Offensive: 16 Sep to 2 Nov 50, inclusive.

1st Mobile Army Surgical Hospital (26 Sep 50)
 1st Prisoner of War Field Hospital (Provisional) (14 Sep 50)
 1st Surgical Hospital (Mobile) (12 Sep 50)
 4th Field Hospital (17 Sep 50)

6th Army Medical Depot Advance Platoon (12 Sep 50)
 6th Medical Depot (26 Sep 50)
 12th Medical Dispensary (12 Oct 50)
 20th Hospital Train (8 Oct 50)
 22nd Hospital Train (8 Oct 50)
 38th Malaria Control Detachment (18 Jul 50)
 52nd Medical Battalion (Separate), Headquarters and
 Headquarters Detachment (24 Sep 50)
 64th Field Hospital (24 Sep 50)
 66th Veterinary Food Inspection Detachment (8 Aug 50)
 95th Veterinary Food Inspection Detachment (5 Jul 50)
 121st Evacuation Hospital (Smb1) (12 Sep 50)
 150th Veterinary Food Inspection Detachment
 (17 Sep 50)
 163rd Medical Battalion (Separate), Headquarters and
 Headquarters Detachment (30 Sep 50)
 171st Evacuation Hospital (2 Oct 50)
 207th Malaria Survey Detachment (17 Jul 50)
 421st Medical Collecting Company (15 Sep 50)
 461st Dental Prosthetic Detachment (Mobile)
 (22 Aug 50)
 476th Veterinary Food Inspection Detachment
 (31 Aug 50)
 514th Medical Clearing Company (4 Oct 50)
 559th Medical Ambulance Company (30 Sep 50)

559th Medical Ambulance Company, 1st Platoon
 (17 Sep 50)
 560th Medical Ambulance Company (30 Sep 50)
 567th Medical Ambulance Company (Separate) (29 Jul 50)
 584th Medical Ambulance Company (Separate) (25 Oct 50)
 618th Medical Clearing Company (Separate) (26 Sep 50)
 629th Medical Clearing Company (9 Oct 50)
 8054th Evacuation Hospital (Smb1) (Base Army Unit)
 (6 Jul 50)
 8055th Mobile Army Surgical Hospital (6 Jul 50)
 8063rd Mobile Army Surgical Hospital (Base Army Unit)
 (16 Jul 50)
 8076th Mobile Army Surgical Hospital (25 Jul 50)
 8211th Army, Medical Administration Detachment
 (1 Nov 50)

When entering individual battle credit on officers' qualification cards (WD AGO Form 66) or on the service record of enlisted personnel (WD AGO Form 24 or DD Form 230), this general order may be cited as authority for such entries for personnel who were present for duty as a member of or attached to a unit listed herein at some time between limiting dates of the campaign.



406TH BLOOD BANK PROSPERS ON GENEROUS DONOR RESPONSE

At 2300 hours on 7 July 1950 less than 2 weeks after the South Korean invasion, the first shipment of whole blood from the 406th Blood Bank was on its way to the fighting forces in Korea.

Dr. George J. Stein, Chief of the 406th Blood Bank, and his assistant, Major

Kathlyn C. Hilton, WAC, recall that at that time the unit had few supplies and no trained personnel. The team, only with great difficulty, succeeded in meeting the critical demands for blood. Today the Blood Bank in Tokyo is a well-equipped, highly-trained organization capable of supplying great quantities of the life-saving fluid weekly.

At various times the unit has split its forces to send two mobile teams into areas other than Tokyo. The collecting peak of these teams and the main bank was reached on 8 December 1950, when 688 pints were collected in one day.

Dr. Stein praised the magnificent response of donors to appeals for blood. American military and civilian personnel as well as other United Nations personnel and the Japanese public have supported the project and its mission, Dr. Stein said.

In August 1951, the "Gallon Club" was formed at the Blood Bank. Six occupationnaires, all of whom had donated eight pints of blood since the outbreak of

the war, qualified as charter members. In ceremonies at the Tokyo installation, a Gallon Club insignia was pinned on each of the six prodigious contributors. "These charter members of the club," Dr. Stein said, "bear testimony to the fact that healthy persons can donate blood regularly and repeatedly without ill effects, even if they donate as frequently as every eight weeks." With each day several more donors become eligible to wear the Gallon Club pin. At the time of publication it is estimated that there are nearly fifty members.

"The need for blood donations continues", Dr. Stein stated, "and we hope that these 'Galloneers' will be an inspiration to people both at home and in the Far East Command to keep up their contributions - - or start now if they have not donated before.

"Soon, in ever-increasing numbers, we'll see this United Nations insignia on people in the streets of Japan, and we'll know that the wearers have made an outstanding contribution to help our wounded fighting men."

United Nations personnel and the Red Cross have provided escort service to the donors. The Red Cross, beginning early last winter, has also shipped thousands of gallons from the United States to Korea, supplementing that supplied by the 406th Blood Bank.

All blood collected by the mobile and road teams is processed at the bank's laboratories in Tokyo. Several additional blood collecting teams have been trained and are available in case of an emergency.

RATES OF CHARGE FOR VETERINARY TREATMENT IN ARMY VETERINARY FACILITIES FISCAL YEAR 1952

The following information has been extracted from Department of the Army Circular 67, 22 August 1951:

"PRIVATELY OWNED ANIMALS AND PETS. - When veterinary supplies cannot be purchased from commercial sources through the facilities of the veterinary nonappropriated fund activity (see AR 40-980), for the treatment of animals and pets owned and maintained by military and civilian personnel at an Army installation, ap-

propriated fund supplies used in the treatment will be charged for by the veterinary officer at rates determined by that officer that will reimburse the Government for the cost thereof. Such determination of cost will not include any charges for professional services. Collections will be deposited by the veterinary officer with the local finance officer to the credit of 2122020 Maintenance and Operation, Army, 1952, Project 1651-99 or 1653-99."

AWARDS TO ARMY MEDICAL SERVICE PERSONNEL

The following additional Army Medical Service personnel have been awarded the Medal of Honor, Distinguished Service Cross, Distinguished Service Medal, Silver Star, Legion of Merit, Soldier's Medal, Bronze Star Medal, Air Medal or Commendation Ribbon for exceptional bravery in face of the enemy and meritorious service during the Korean conflict.

DISTINGUISHED SERVICE CROSS

Atchley, Oren C., Lt Col, MC
Nabors, John H., PFC

DISTINGUISHED SERVICE MEDAL

Dovell, Chauncey E., Col, MC

SILVER STAR

Alverson, Richard F., Sgt
Banks, Robert L., PFC
Bettencourt, Ernest, Sgt
Campbell, Gilbert S., Capt, MC
Canada, Charles C., Col, MC
Clower, Erskine L., Sgt
Doby, Richard M., Sgt
Donaldson, Paul L., Sgt
Douglas, Harold, Sgt
Flynn, Phillip D., Pvt
Gros, William A. Jr., Cpl
Harris, John F., Lt Col, MC
Johnson, Leonard F., Sgt
Johnston, Paul E., Cpl
Jordan, Anthony, PFC
Lema, Antone, Cpl
Lemay, Edward F., 1st Lt, MC
Levi, Robert O., 1st Lt, MSC
Marrero, Luis M., Sgt
McLean, John W., Sgt
Mensay, Tom R., Sgt
Miller, James A., 1st Lt, MC
Montano, Marino, Cpl
Narvaez, Montalvo M., PFC
Navarre, Vincent J., Capt, MC
Paschall, Clent D., PFC
Petrillo, Armand P., PFC
Roberts, Richard A., Sgt
Sandusky, Walter S., Cpl
Sterns, James W., Sgt
Waem, Richard L., PFC
Wallace, Jack E., Sgt
Weaver, Charles E., Cpl
Webb, Coy, Cpl
Willard, George Jr., Sgt

LEGION OF MERIT

Ahern, Archibald, Maj, MC
Blanchard, Gerald E., Maj, MC
Bradley, Ruby G., Maj, ANC
Draper, Stuart I., Lt Col, MC
Galloway, Marie S., Lt Col, ANC
Gordon, James H., Col, MC
Hagman, Frank E., Col, MC
Hamrick, William A., Lt Col, MSC
Johnson, Harry G., Col, MC
Kowalsky, Matthew J., Lt Col, MC
Leech, Homan E., Col, MC
Minerva, Frank D., Lt Col, MC
Newsom, Samuel J., Lt Col, MC
Raulerson, Charles, Lt Col, MSC
Reiner, Ralph E., Lt Col, MC
Russell, Joseph P., Col, MC
Taylor, Harlan H., Col, MC
Van Buskirk, Kryder, Lt Col, MC

SOLDIER'S MEDAL

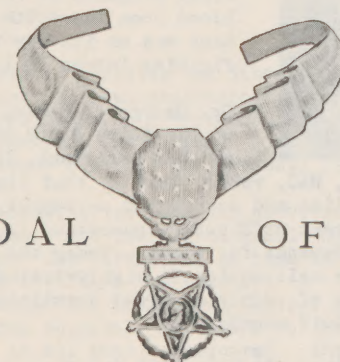
Sanders, John L., Cpl

BRONZE STAR MEDAL with "V"

Alessi, Sebastain A., Sgt
Arnett, Norman L., Capt, MC
Avila, Gonzala, Sgt
Back, George R., Sgt
Baker, Harold E., Sgt
Baldwin, John V., PFC
Bonaparte, Charles, PFC
Burke, Robert G., PFC
Burrell, Arthur P., Sgt
Carey, Wallace C., M/Sgt
Cennamo, Sebastian, 1st Lt, MSC
Chelette, Charley S., PFC

Kalinowski, Henry, PFC
Kats, Harold J., PFC
Ke, Nicholas K., Cpl
Kelleher, Harold A., Sgt
Ketcham, Harvey F., Cpl
Landers, Charles E., PFC
Lillard, Robert R., PFC
Little, Steve M., Sgt
Long, Howard M., Cpl
MacDonald, Lawrence, Sgt
Madrid, Eloy, Sgt
Maldonado, Angel W., Sgt
Markum, Eldon L., Capt, MSC
Martin, Walter L., Cpl
Marvin, Raymond A., Sgt
Matthess, Charles R., Sgt
Maupin, Donald S., Cpl
Montalbo, Isaac G., Cpl
Moseley, Thomas H., Capt, MC

MEDAL OF HONOR



Claymore, Merle P., Cpl
Colvin, James M., Cpl
Corgill, Howard R., Sgt
Craford, Bobbie L., Cpl
Cuthbert, James, Cpl
Dahl, Clifford A., Sgt
Danaj, Joseph F., SFC
Delane, Jerry, PFC
Dodson, Charles, Cpl
Duran, Rudy, PFC
Fountain, Carl, Cpl
Garcia, Gunnersindo, Sgt
Gents, James P., PFC
Guerrero, Arthur B., Sgt
Hardaway, Cecil E., PFC
Harkins, Charles T., Sgt
Hays, James C., PFC
Hild, Merele C., Sgt
Hillyard, Robert L., SFC
Hockney, Victor H., Cpl
Huggins, Lewis H., 1st Lt, MSC
Hutchings, Jesse H., Sgt

Murata, Steven S., Cpl
Myers, Robert G., Cpl
Neff, Richard H., Cpl
O'Bryan, Francis N., Sgt
O'Campo, Jose J., Sgt
Pederson, Albert L., Cpl
Piazza, John W., PFC
Pierce, Robert L., M/Sgt
Quinones, Hernandez, Cpl
Radocchio, Robert A., PFC
Reynolds, Winfred L., Pvt
Rivera, Benito, Sgt
Roberts, Richard S., Sgt
Rodrigo, Angelo L., Cpl
Sandmeier, Ben, Sgt
Satterelli, John R., Cpl
Schnurr, Gerald L., Sgt
Scholz, Ralph J., SFC
Seale, Franklin D., SFC
Sevalstad, Carl E., Sgt
Sexton, Kenneth V., Cpl
Sherrill, Clyde R., Sgt

Snell, Maynard J., Capt, MSC
Staves, Lemuel M. Jr., Cpl
Stratton, Gerald L., Sgt
Tiller, Paul W., Cpl
Todd, Charles I. Jr., Cpl
Tucker, Alfred N., Capt, MSC
Ward, Keltz B., Sgt
Ward, Scott, Sgt
Waters, James D., Sgt
Watkins, William Z., Cpl
Watson, Marion N., Cpl
West, John R., Sgt
White, Charles E., Cpl
Worden, Herman Lt., Cpl
Zurbrick, John H., PFC

BRONZE STAR MEDAL

Ables, William M., Sgt
Adkins, Howard, Sgt
Agnor, Charles M., M/Sgt
Amaro, Miguel, Cpl
Anstice, Robert
Beard, Harry C., Cpl
Beese, Manning H., Cpl

Fenster, Murray, Sgt
Fisher, George W., Capt, MC
Flacco, Albert J., Capt, MC
Frechette, Anthony, Sgt
Gay, Clyde, SFC
Gee, Vernon R., Maj, MC
George, Arseal, Sgt
Harrison, Billy R., Sgt
Hausman, William, Maj, MSC
Hicks, Granville, M/Sgt
Hiebert, Leonard P., Capt, MSC
Hillyard, Robert L., M/Sgt
Hitchings, Donald L., Maj, MSC
Hume, Robert D. Jr., Capt, MC
Hurla, Kenneth C., SFC
Ingle, Chester B., Sgt
Jackson, Robert H., Maj, MC
Johnson, Ernest E., Cpl
Johnson, Chaezell, Cpl
Jones, Kenneth N., SFC
Jones, Moses C., Cpl
Kemp, Asa V., M/Sgt
Kepes, Joseph D., Capt, MC
Kotarak, Joseph J., Sgt
Kynch, James H., Cpl

Richards, Herman, Capt, MSC
Richards, Clark L., Sgt
Richardson, Jesse L., Cpl
Schirmer, Jacob F., Capt, MC
Slovak, Sophia, Capt, ANC
Smith, Benjamin N., 1st Lt, MSC
Smith, John R., SFC
Soule, Rublee C., Maj, MC
Stack, Andrew J., Lt Col, MSC
Starling, William, Sgt
Swan, Halbert W., Cpl
Vanier, Clarence G., Cpl
Whitner, Olan L., Sgt
Wilson, Jon M., Capt, MC

AIR MEDAL

Canada, Charles C., Col, MC

COMMENDATION RIBBON

Abrams, Joseph T., 1st Lt, MSC
Adams, Henry W., Cpl
Ballard, Garland J., Pvt
Bartok, Joseph, M/Sgt
Bates, Gerald E., PFC
Benton, John L., Capt, MSC
Borrego, Delio, Cpl
Bramer, Gale A., Cpl
Carmichael, Turner, 2d Lt, MSC
Carroll, Arthur, Cpl
Daily, Robert W., Capt, DC
Danaj, Joseph F., SFC
Davis, Arnold B., Sgt
DeBusschere, Robert, PFC
Doster, Junior H., PFC
Dovell, Chauncey E., Col, MC
Etheridge, Willard, Sgt
Fick, Albert E., Capt, MSC
Gant, John Jr., PFC
Green, Robert W., SFC
Hale, Roscoe T., PFC
Harris, John F., Lt Col, MC
Hobbs, Battie T., SFC
Jackson, James C., Cpl
Jarvi, Rudolph M., Capt, MC
Johnson, Charles N., Cpl
Johnson, Earl M., PFC
Johnson, Joseph H., Pvt
Jones, Edward, M/Sgt
Jones, James E. D., PFC
Kilby, Lee J., Cpl
Lew, Arlis L., Cpl
Littlefield, S.S.M., Sgt
Lower, Robert W., 1st Lt, MSC
Martin, Carl, 2d Lt, MSC
McDonald, Alexander, Cpl
McKinney, Herman D., Sgt
McNair, Joel N., Maj, MSC
Miller, Lester P. Jr., Cpl
Moseley, Thomas H., Capt, MC
Ocampo, Jose J., Sgt
Painter, Edward J., Sgt
Payne, Kenneth N., Capt, MC
Perrigoue, Lawrence, PFC
Rehme, William G., Sgt
Reidel, Charles H., Cpl
Rucker, Julius T. Jr., Capt, MC
Sanchez, Marcelino, Cpl
Sanders, Willie, Sgt
Saunders, Raymond Jr., Sgt
Seale, Franklin D., SFC
Shute, Kenneth G., Cpl

Continued on next page

Private First Class Richard G. Wilson

By direction of the President, under the act of Congress approved 9 July 1918 (WD Bul. 43, 1918), the Medal of Honor for conspicuous gallantry and intrepidity at the risk of life above and beyond the call of duty is awarded posthumously by the Department of the Army in the name of the Congress to the following-named enlisted man:

Private First Class RICHARD G. WILSON (Service No. RA 17252005), Medical Corps, United States Army, a member of Medical Company, 187th Airborne Infantry Regiment, distinguished himself by conspicuous gallantry and intrepidity above and beyond the call of duty in action near Opari, Korea, on 21 October 1950. As medical aid man attached to Company I, he accompanied the unit during a reconnaissance in force through the hilly country near Opari. The main body of the company was passing through a narrow valley flanked on three sides by high hills when the enemy laid down a barrage of mortar, automatic-weapons, and small-arms fire. The company suffered a large number of casu- (continued on next page)

Bell, James G., Sgt
Belt, Warren H., Capt, MC
Bethart, Hector, Maj, DC
Black, Clifford E., 1st Lt, MSC
Bolden, D. W., Cpl
Bowser, William C., PFC
Brey, Calvin J., Sgt
Brown, Eldon R., Sgt
Carter, Lawrence, Cpl
Cason, Vernal C., Cpl
Church, Eleanor C., 1st Lt, ANC
Cook, Dudley P., Capt, MSC
Crouch, Richard L., Cpl
Croxtan, Logan, Cpl
Cummins, Carl E., Maj, MSC
Devall, Jerome H., SFC
Douglas, Henry C., 1st Lt, MSC
Douglas, Robert M., SFC
Dovensky, Michael, Capt, MSC
Elmore, Herbert R., Maj, MC
Euggins, Lewis H., Capt, MSC
Faust, Eleanor S., Capt, ANC

Lamarr, Otchell L., Cpl
Lenn, Claude R., Capt, MSC
Levi, Robert O., 1st Lt, MSC
Lewandrowski, Archy, Capt, MC
Licea, Frank Sr., Sgt
Ligon, Vernon H., Cpl
Lindsey, Oscar J., Cpl
Little, Steve M., Sgt
Lynch, Leo J., 1st Lt, MSC
Martin, Carl, 2d Lt, MSC
McClure, Ronnie, Jr., Sgt
McCray, William L., 1st Lt, MSC
McLaughlin, John F., Maj, MC
McNamara, Margaret, Capt, ANC
Meyer, Arnold W., Cpl
Morse, Justice A., SFC
Neiman, Watson E., Lt Col, MC
Neville, George W. J., Capt, MSC
Newsom, Samuel J., Lt Col, MC
Nordine, Oliver W., Cpl
Ragsdale, Willie J., Cpl
Reed, David, Sgt

Commendation Ribbon (Continued)

alties from the intense hostile fire while fighting its way out of the ambush. Private Wilson proceeded at once to move among the wounded and administered aid to them, oblivious of the danger to himself and constantly exposing himself to hostile fire. The company commander ordered a withdrawal as the enemy threatened to encircle and isolate the company. As his unit withdrew, Private Wilson assisted wounded men to safety and assured himself that none were left behind. After the company had pulled back, he learned that a comrade previously thought dead had been seen to be moving and attempting to crawl to safety. Despite the protests of his comrades, unarmed and facing a merciless enemy, Private Wilson returned to the dangerous position in search of his comrade. Two days later, a patrol found him lying beside the man he returned to aid. He had been shot several times while trying to shield and administer aid to the

wounded man. Private Wilson's superb personal bravery, consummate courage, and willing self-sacrifice for his comrades reflect untold glory upon himself and uphold the esteemed traditions of the military service.

General Orders
No. 64

DEPARTMENT OF THE ARMY
Washington 25, D.C., 2 August 1951

Medal of Honor (Continued)

Smith, Marriion L., PFC
Spitzer, Jack R., SFC
Stroder, Albert, Cpl
Swanson, Arthur, Sgt
Thompson, John W., 2d Lt, MSC
Tucker, Alfred N., Capt, MSC
Underwood, Jack D., Cpl
Williamson, Harry F., Sgt

AUTHORIZATION FOR MEDICAL CARE

The following questions were recently propounded to the Office of The Surgeon General, Department of the Army, Washington 25, D.C.:

Question No. 1 - Request clarification of AR 40-506, dated 9 October 1950, as changed, with reference to authorization of medical care for widows of military personnel.

Question No. 2 - Request further interpretation of paragraph 5 e (5) AR 40-506 as to whether or not members of Reserve Components are eligible for medical care, who are retired for length of service, twenty years or more, other than for physical disability and retired at age of 60 by reason of retirement credits earned while on inactive duty status.

Reply to the above questions is as follows:

Question No. 1 - AR 40-506 does not presently au-

thorize medical care for widows of Armed Forces personnel. A proposed change to cited Army Regulation has been forwarded which will, if approved for publication, authorize medical care for unremarried widows of deceased Armed Forces personnel whose death occurred while on extended active duty or while in a retired status on a "when adequate facilities are available basis." This medical care will be at the rate established for dependents for active duty personnel.

Question No. 2 - Members of the reserve components retired under the provisions of Title II, PL 810, 80th Congress, are authorized medical care, i. e., those retired for over 20 years active federal service. Persons retired under provisions of Title III, PL 810, 80th Congress, are not authorized treatment.

IMPROVISED PATIENT'S BEDSIDE TABLE

Major Robert L. Jetland, MSC, 8211th Army Unit, Swedish Red Cross Hospital

An easily constructed patient's bedside table for hospitals operating in the combat zone can be made from a salvage part of a 500 lb. bomb fin assembly. A steel crating that supports the fin assembly of a 500 lb. bomb is an item of salvage once the bombs are uncrated and are easily obtained at supply points at the airfields.

The bedside table is put together by removing the side spot-welded iron braces of one of the supports. This makes the upper half of the bedside table and is placed on top of another support that has these side braces left on. The four legs of the top support are welded at the corners. The top surface of the supports has a dished surface of about 5" in diameter and 1/2" deep and a piece of plywood to cover the top makes a desirable top surface. A metal rod can be

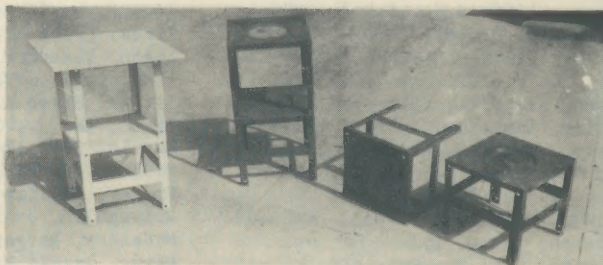


Fig. 1 Patient's bedside table with plywood top
Fig. 2 With side braces removed from one support and then spot-welded at four corners
Fig. 3 Steel supports from a 500 lb bomb fin assembly

easily welded to one side of the top surface to make a towel rack for the table.

The main advantages of such a bedside table are that first it provides a place for a patient to place his personal belongings, water glass, etc., in a uniform

manner. Secondly, the steel supports are readily available in the combat zone where the semi-mobile and mobile hospitals are deployed and of which most do not have bedside tables as part of their table of allowances. The third advantage is that the tables are easily and readily constructed from salvage parts.

CYSTOSCOPIC TABLE FOR FIELD USE

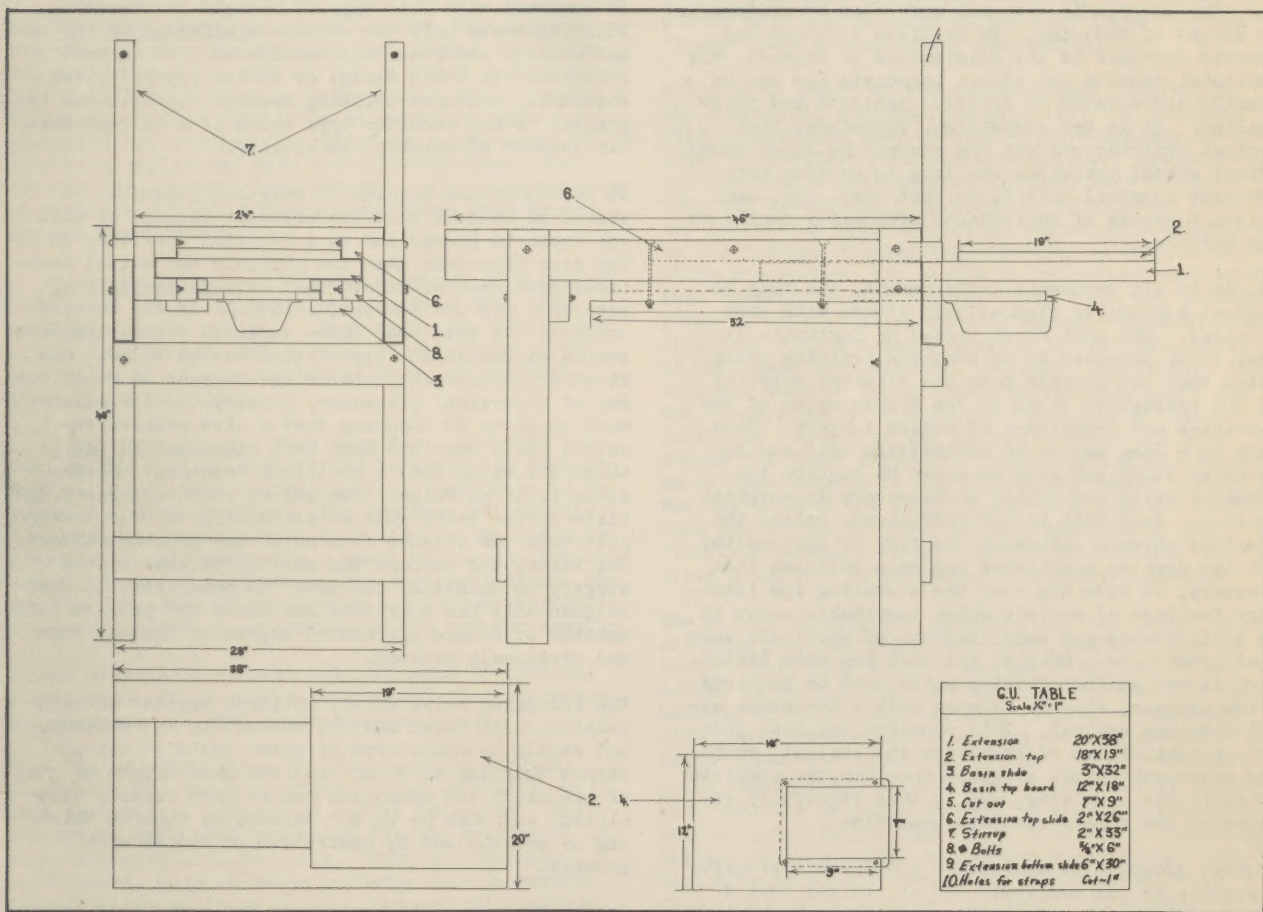
A simplified cystoscopic table for field use has been constructed by Sergeant George P. Perez of the 121st Evacuation Hospital (Smb1), APO 301.

Sgt. Perez improvised this table from available material starting with a few 2"x4", 2"x6" and 2"x2" pieces of lumber. One half inch plywood 24"x40" was used for the top, and the basin was made from a #10 can. Any other container no larger than 8" in diameter and 10" deep could have been used. The brace that holds the stirrups in place can be constructed from any material that will fold, like steel sheeting

or tin.

The accompanying diagram illustrates the sergeant's solution to the problem. It can be seen that variations and substitutions of materials are easily accomplished in accordance with supplies available in the field.

The table illustrated is now in use at the 121st Evacuation Hospital and has proved to be quite satisfactory for cystoscopic examinations.

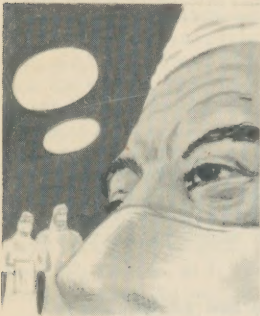


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PSYCHOLOGICAL ASPECTS OF SURGERY

Colonel Albert J. Glass, MC, Neuropsychiatric Consultant, Medical Section, GHQ, FEC
Colonel Frank E. Hagman, MC, Surgical Consultant, Medical Section, GHQ, FEC

The skill and effectiveness of the surgeon has steadily increased during our modern era. Aided and stimulated by discoveries in physiology, anesthesia, and antibiotic drugs, the scope of the present day surgical specialist has greatly expanded. He has been enabled to operate freely in

anatomical regions previously forbidden and to perform what seemed to be surgical miracles only a few years ago. With this growth in technique and knowledge, the surgeon is now even more than heretofore the Knight of Medicine. He utilizes a direct and dramatic approach to the elimination of disease. His beneficial results are almost immediate and can be promptly appreciated by grateful patients and their families. It is not surprising, therefore, that surgical training centers are stormed by eager young medical school graduates who long to possess this marvelous surgical ability so that they, too, can achieve a degree of omnipotence ordinarily denied to most mortals.

But, as in all worthwhile attainments, the road to surgical success is figuratively strewn with many obstacles. One must first indeed be fortunate in order to be accepted by an adequate training institution that can provide both the clinical material and the preceptors vital to the transmission of the principles and techniques of modern surgery. Then there is a long period of unrelenting toil and devotion to study and work in order to acquire the automatic skill and timing so necessary in surgical practice. Even this is not sufficient, unless the potential surgeon possesses the type of personality that can develop confidence and even boldness when necessary, to tide him over the sickening and inhibitory feelings of anxiety which inevitably occur in the vicissitudes and complications of difficult surgical procedures. Despite all that has been stated, there is yet another faculty which must be acquired by the surgeon, else he becomes only a technical expert with the scalpel. This concerns surgical judgment, a combination of knowledge and insight, which when possessed by the surgeon makes him the complete artist in his specialty, who is then rightfully entitled to the honors bestowed upon him.

Surgical judgment is admittedly a difficult property to acquire by the aspirant. It is obvious that a wide experience of many and varied types of surgical patients is necessary to provide a background or framework of reference in order that the surgeon may make valid comparisons with any current problem.

However, there is another and perhaps less understood component of surgical judgment. This relates to the ability of the surgeon to consider genuinely the ultimate total function and welfare of the individual in whom a surgical procedure is contemplated. It is

well known that everyone pays lip service to the concept of the total personality, yet it is obvious that many of the errors in surgery occur because surgical judgment is faulty in this particular aspect. It is with this component of surgical judgment that this paper is mainly concerned.

At the outset it should be made clear that such a concept of the functioning of a total person involves abstract thinking. This is an ability possessed by all to a varying degree which enables us to conceive mentally of an idea, theory or concept which is not a direct product of the ordinary senses, but synthesized as it were, by the highest of our mental faculties. In contrast with this type of thought is concrete thinking where only the evidences afforded by the usual sensory receptors are considered. It is well known that in brain damage or severe psychological disorders, abstract thinking becomes impaired and regresses to the concrete type which is a characteristic feature of cerebral incapacity.

To return to our problem of surgical judgment, it should be evident that the abstract concept of what one hopes to accomplish by a surgical operation is far more important than the concrete and actual technical performance, albeit that this is absolutely necessary for the successful outcome of the abstract concept. To this end, three surgical principles have become axiomatic and are of time-tested value. The first dictates that whatever one chooses to do in the way of a surgical procedure, primary consideration must be given to insuring that a live patient results. This does not mean that risks should not be taken but warns that a brilliant technical success alone is of no value. The second rule of surgery insists on the basic goal of attempting to remove or alleviate the disease from which the patient suffers. The third, and perhaps the most difficult rule of surgery to maintain, concerns the admonition to the surgeon that his operation not leave the patient with another or a more aggravated degree of disease than was previously present.

The foregoing rules do not militate against the calculated risks which must be assumed by the surgeon, but should be considered as guide posts in his abstract thinking in order that the main object or goal of his skill and technique can be more readily visualized, and that he be not deluded by wishful thinking or overwhelmed by admiration of his surgical prowess.

In the further consideration of the third rule of surgery, which warns against iatrogenic damage (damage generated by the surgeon himself) to the patient, it is evident that this is the zone of consideration where the concept of the total person plays its largest role. It is here that one must consider the entire physical body rather than a locally diseased part and, even more important, it is here that the psychological aspects of the person as well as his soma can be seriously injured. From this standpoint, surgical

procedures can be roughly divided into the following categories:

1. Emergency Surgery: There is no doubt concerning the necessity of operation. The patient is certain to die very soon unless something is done at once. Time is of the essence. No consideration can be given to any other factor than immediate operation to achieve the first rule of surgery, i.e., a live patient, regardless of consequences. In such instances the surgeon will perform a tracheotomy with a crude knife, heedless of possible infection, or reach in with unwashed hands to stem serious arterial bleeding, or decompress tension pneumothorax by any means at hand, or rapidly open the chest and massage the heart in cardiac arrest. The important principle is speed in decision and in execution.

2. Urgent Surgery: Speed is not so essential but the pathology is such that demands prompt surgical intervention to ward off a catastrophe. Surgical treatment is urgent in ruptured spleen, strangulated hernia, gangrenous appendicitis, volvulus of the colon, and epidural bleeding.

3. Necessary Surgery: There is even less urgency but the pathology is definite and chronic for which the symptoms of the patient are a direct consequence. The connection between pathology and symptoms makes it fairly certain that surgical procedure offers an excellent opportunity for relief or improvement. Such cases are gallstones with intermittent common duct obstruction, chronic lung abscess, large ovarian cyst or carcinoma of the rectum or meningoma with neurological manifestations.

4. Elective Surgery: Definite evidence of pathology is present but it is not at all certain that the symptoms will be removed. Such cases are often seen in the form of deviated septum, chronic tonsillitis, protrusion of an intervertebral disc, or retrodisplacement of the uterus.

5. Doubtful Surgery: This comprises operative procedures for dubious indications in which the ultimate results are at best unpredictable. Varicocele is an example of this category. The symptoms of pain in the groin and scrotum with radiation to the thigh in a neurotic young male with a small varicocele are extremely doubtful indications for varicocelectomy. The results are often disappointing and indeed iatrogenic trauma frequently is engrafted on the symptom complex.

In the absence of demonstrable evidence of ureteral obstruction, it is extremely doubtful that operation for nephroptosis will prove to be salutary.

From the military view, doubtful surgery includes procedures for the correction of long-standing skeletal deformities present in recent inductees. Many operations have been performed for the correction of such deformities in the past. Despite anatomical improvement, many of these patients come to separation from the military service via medical channels.

6. Wishful Surgery: There is no objective evidence of a disease process but the patient's symptoms seemingly demand an attempt by the surgeon to do something. The surgeon is motivated to activity on a hunch, because of pressure by the patient or the patient's family, or because one's own intolerance of inactivity cannot be withstood. It is in this group that explorations to find out what might be causing the abdominal symptoms are common. Also repeated amputations for "phantom limb", application of casts

to correct camptocormia or to cure backache are undertaken.

The above classification is not put forth for finite reasons. Others may devise a more accurate categorization for the indications of surgical intervention. For our purposes, it serves merely to illustrate the mechanism of abstract thinking in surgical judgment which is usually more or less intuitively performed by the experienced surgeon. The various groups that are listed in this classification indicate the degree to which surgical judgment must be exercised. It is evident that the need for considering the total personality concept increases as the absolute necessity for surgery decreases. It is in the realm of elective, doubtful or wishful indications, that it becomes more and more difficult to maintain the third rule of surgery and thus prevent iatrogenic trauma. For here the personality of the patient assumes a more prominent role in the results of the surgeon who must understand and utilize the concept of how the individual is going to function in a given environment. Failure to consider the total functioning of the person may cause the surgeon to produce only a technical correction which may have either no effect upon the capacity of the individual to work, or may cause a fixation of symptomatology.

Everyone is aware of the complications inherent in the surgery of compensation practice. It has been well established that certain individuals may be enabled by surgical procedures to solidify symptomatology and thus consciously or unconsciously obtain a tangible benefit by a persistence of illness. This may occur even when surgery is urgent or necessary, to say nothing of elective, doubtful or wishful operative procedures. It should be recognized that even when compensation is not involved, there are persons prone to utilize illness as an escape from adult obligations with the added dubious but definite gains of childhood helplessness. In such individuals, the surgical scar is the hallmark of respectability and the cornerstone of a secure defense against either their own insight or the critical evaluation by others for their failure to make a better adjustment. An extreme example is the well-known female patient who has endured the suffering of multiple but fruitless operations in order to gain the unhappy but vicarious pleasure of an invalid who then can rule those about her by the power of chronic symptoms.

The errors of surgical judgment that can occur in civilian practice apply with even greater force in the military sphere where the gains of illness are almost as tangible as in compensation practice. The hazards of combat and the deprivations of overseas life provide powerful incentives to utilize the honorable excuse of physical incapacity for practical goals unobtainable by any other method. It is important that the military surgeon be aware that operation is prima facie evidence of a previous disabling disease process. This can affect his results, particularly in elective or doubtful cases which are vulnerable to iatrogenic fixations. In military life it becomes all important that the surgeon think of the ultimate result of such surgical procedures. He must answer the question: Will the patient be able to continue duty performance as he did prior to the operation? In many individuals, conservative non-operative treatment may permit them to continue duty with a chronic but nondisabling condition, such as an uncomplicated pilonidal cyst, whereas even a technically successful operation will prevent duty for an indefinite period after which the soldier may no longer be motivated to resume his previous hardships

and hazards. In this connection, the military surgeon like other medical officers must give primary consideration to the needs of the group rather than the desires of the individual.

Perhaps the largest obstacle to acquiring the faculty of good surgical judgment lies in the personality of the surgeon. The same character traits of confidence and boldness which stand him in good stead during the trials and tension of difficult surgical procedures may also contribute to an omnipotent attitude toward his opinions. However, the indications or decisions as to a surgical procedure require more abstract thought and less concrete conclusions. The emotional attitude of superiority and omnipotence may readily defeat good surgical judgment as it tends to force the surgeon to adhere to his diagnoses and recommendations despite evidence to the contrary and the judgment of others. The wish to be infallible militates against the concept of how the surgical procedure will affect the later functioning of the person. This pitfall is rectified as the surgeon comes to have a genuine confidence in his ability. It is then no longer necessary to maintain an attitude of omnipotence as a defense against inexperience and inner feelings of doubt. The more experienced surgeon tends to have better surgical judgment, in part because he has arrived, so to speak, and no longer has to prove himself. He can relax and utilize his available extra energy toward abstract thinking about the patient rather than feel impelled to action because of an inner emotional need to do something.

The possession by the surgeon of undue confidence and boldness may also contribute to an omnipotent attitude toward his ability to undertake almost any surgical procedure, heedless of his personal limitations and the inadequacies of auxiliary support so vital for successful surgery. Thus he may wantonly enter upon a course of action demanding skill and aid not possessed by him, to the end that the welfare of the patient is placed in unnecessary jeopardy. Surgical judgment includes the examination of one's inner resources and the environment to determine whether or not a given surgical problem should be treated by him or better referred to a surgeon more experienced and more technically qualified and in a more favorable setting.

One other facet of surgical judgment in military life relates to the evacuation policy of an overseas theater. It is generally agreed that such a policy is necessary. In the Far East Command, experience has demonstrated that usually it is wise to return patients to the United States or other United Nations when it is likely that they cannot be returned to duty within a period of 120 days. It becomes a matter of surgical judgment, therefore, to reach a decision concerning the likelihood of returning the patient to duty within this period prior to embarking on a surgical procedure not requiring urgency.

For one or more reasons discussed in this paper, it is in general good surgical judgment not to operate in overseas hospitals patients with certain disabilities. Examples of these are:

1. Internal derangement of the knee joint.
2. Intervertebral disc pathology.
3. Skeletal deformities existing prior to induction into the service.
4. Radical operation for malignant neoplasm in ab-

sence of complications demanding prompt intervention.

5. Major plastic operations.
6. Surgical procedures for chronic osteomyelitis.
7. Definitive operations for tuberculosis.
8. Gastric resection for peptic ulcer not responding to medical treatment and without complications demanding prompt intervention.

A paramount function of the medical services is to conserve the efficiency and effectiveness of the Armed Forces by all the techniques of the art and science of medicine. The morale of our fighting men is closely related to the welfare of its dependents. Clearly, when a wife or a child is stricken by illness the soldier husband or father cannot function as he should until relieved of his anxiety. It thus becomes the privilege and responsibility of the surgeon to do his utmost on behalf of the soldier and his dependents.

The concepts of surgical judgment which have been discussed apply equally to the surgical care of dependents with one notable difference. It is not important to consider the limiting factor of return to duty in a specified time. Thus an operation may be performed when the surgical indications are clear to enable the retention of the soldier in the command.

In summary, it is recognized that great strides have been made in the scope of surgery, during our modern era. The successes and the drama of surgery have attracted many young men who aspire to be surgeons. The difficulties of obtaining training are many and the road to success is beset with pitfalls.

The combination of knowledge and insight, known as surgical judgment, in addition to other qualifications, must be possessed by the surgeon to make him complete in his profession. Admittedly difficult to acquire, surgical judgment involves abstract thinking. It includes the abstract concept of what one hopes to accomplish by a surgical operation or refraining therefrom.

To obtain a live patient with the diseased process removed or alleviated, and without leaving him with another or more aggravated disease than was present previously, are basic aims of surgery.

Surgical procedures are roughly divided into categories serving to illustrate the mechanism of abstract thinking in surgical judgment. The purpose is to indicate the need for considering the total personality of the patient increasingly as the absolute necessity of operation decreases and thus prevent iatrogenic trauma.

It should be recognized that certain individuals may be enabled by surgical procedures to solidify symptomatology and thus consciously or unconsciously obtain tangible benefits by persistence of illness. Thus illness becomes a means of escaping adult obligations with the added dubious gains of childhood helplessness. The hazards of combat, and the deprivations of overseas life provide powerful incentives to utilize the honorable excuse of physical incapacity for practical goals not obtainable by other means.

Surgical judgment encompasses the personality of the surgeon himself. The character traits of boldness and confidence may contribute to an omnipotent atti-

tude toward his opinions and his abilities, thus forcing him to adhere to his diagnosis and recommendations despite evidence to the contrary or the judgment of others, or to undertake an operation for which he lacks the training, qualifications, or sur-

roundings to perform.

In military practice, surgical judgment involves considerations peculiar to the service and implications bearing upon the mission of the Medical Service.

ACUTE BLOOD DYSCRASIAS

Lt. Colonel Dunham Kirkham, MC, Chief, Medical Service, 10th Station Hospital

Blood dyscrasias in the Far East are not more common than or different from those found elsewhere. However, because certain diseases are prevalent here, the differential diagnosis of some symptoms and signs takes on new aspects.

For instance, an abnormal bleeding tendency manifested by petechiae, conjunctival hemorrhages, and epistaxis makes one think of an acute thrombopenia. Here one should think of relapsing fever perhaps first, especially as the patients are often afebrile at a time when they are critically ill. Other common causes in this area are typhus, Weil's disease, severe cases of smallpox and measles, septicemias with meningococcus or other organisms, and severe penicillin reactions.

A profound leukopenia may suggest an aleukemic leukemia, but is usual in dengue and phlebotomus fever, and occurs in some cases of smallpox and other virus diseases. The presence of fever and absence of anemia are of course helpful. In doubtful cases, smears of the buffy coat from sedimented blood should be examined for abnormal cells. Infectious mononucleosis is not uncommon.

When abnormal white blood cells are found, with either high or low total count, the possibility of a leukemoid reaction to acute infection should be considered. Juvenile forms of all the blood cells may occur in severe infections such as smallpox, typhus, relapsing fever, and septicemias.

A combination of jaundice, anemia, and splenomegaly suggesting one of the hemolytic anemias may be due to chronic malaria, although untreated malaria is

uncommon in American personnel. It is sometimes seen among our allies from such areas as Indo-China, Thailand, India, and Ethiopia. They may also have kala-azar, schistosomiasis, etc. The most common causes of jaundice in Korea are virus hepatitis first, relapsing fever second, and then probably malaria and mononucleosis. Cirrhosis and biliary obstruction are low on the list.

A profound anemia suggestive of pernicious anemia is often seen in indigenous persons with severe hookworm infestations; they may also have considerable abdominal pain and nutritional edema.

A marked eosinophilia is relatively common in the Far East. Parasitic infestation is the usual cause, and should suggest stool examinations and other studies.

There may be few laboratory facilities in some of the forward areas, both in equipment and technicians. However, the trained eye and brain are worth any amount of elaborate facilities. With a microscope, a few slides, and a bottle of stain the enthusiastic doctor can solve most of his hematological problems if he is willing to examine carefully a simple blood smear. He can make a fair estimate of the number, size, shape, and hemoglobin content of the red cells. He can detect the parasites of malaria and relapsing fever. He can assess fairly accurately the adequacy of platelets in hemorrhagic cases. The presence or absence of occasional normocytes, reticulocytes, and myelocytes give information on bone marrow stimulation or depression; and he can diagnose leukemia and mononucleosis. The following table is reproduced from the HANDBOOK OF MEDICAL MANAGEMENT.

BLEEDING DISEASES - SUMMARY OF DIAGNOSIS AND TREATMENT

Mechanism and Diagnostic Criteria		Diseases	Treatment
Blood Clotting Abnormalities	Hypoprothrombinemia	Hemorrhagic disease of newborn.	Menadione (Vitamin K).
	1. Prothrombin time prolonged.	Avitaminosis K.	Menadione (Vitamin K).
	2. Clotting time prolonged.	Hepatic disease.	Treat hepatic disease.
	3. Bleeding time prolonged.	Dicumarol toxicity.	Regulate or discontinue Dicumarol dosage.
		Heparin toxicity?	Regulate or discontinue heparin dosage.
	Hypothrombinemia		
	1. Clotting time prolonged.	Heparin toxicity.	Regulate or discontinue heparin dosage.
	Fibrinopenia		
	1. Blood fibrinogen decreased.	Hepatic disease.	Treat hepatic disease.
	2. Prothrombin time prolonged.	Congenital fibrinopenia.	Blood transfusions.
	Unknown		
	1. Clotting time prolonged.	Hemophilia.	Transfusions of fresh whole blood, anti-hemophilic globulin, or of plasma and supportive measures.
		Pseudohemophilia.	

Platelet Abnormalities	Thrombocytopenia 1. Platelets decreased. 2. Clot retraction time prolonged. 3. Bleeding time prolonged. 4. Capillary fragility increased.	Idiopathic thrombocytopenic purpura. Acquired thrombocytopenic purpura. Leukemia. Hypersplenism.	Acute phase - Whole blood transfusions and supportive measures. Convalescent phase - Splenectomy. Acute phase - Whole blood transfusions and supportive measures. Remove toxins when present. Splenectomy.
Blood Vascular Abnormalities	Vitamin C Deficiency Capillary fragility increased. Allergic Vascular Phenomena Capillary fragility increased. Congenital Vascular Defect Capillary fragility increased. Thrombocytopenic Purpura? Capillary fragility increased. Systemic Infections 1. Clotting time prolonged. 2. Capillary fragility increased. Vascular Toxins Capillary fragility increased.	Scurvy. Allergic purpuras. (Henoch's, Schonlein's) Hereditary hemorrhagic telangiectasia. Idiopathic thrombocytopenic purpura. Subacute bacterial endocarditis. Drug intoxication. Snake venoms.	Ascorbic acid. Removal of allergens when possible, blood transfusions. Antihistaminic drugs. Prophylactic high ascorbic acid and adequate Vitamin K. General anti-hemorrhagic measures. 1. See under thrombocytopenic (above). 2. Splenectomy. Specific anti-infective measures. Discontinuation of drug. Specific antivenin therapy

In summary, it is well to keep in mind the prevalence of certain acute infections which are rare in the

United States and which may simulate some of the signs and symptoms of acute hematologic conditions.



PROBLEMS FOR STUDY BY RESEARCH IN THE FIELD

Colonel Frank E. Hagnan, MC, Surgical Consultant, Medical Section, 3HQ, FEC

Recently, many of us had the privilege of knowing Dr. Fiorindo Simeone, Maj. Curtis Artz, Capt. George Schreiner, and Lt. Russell Nelson, members of a Research Team for Medical Investigation in the Field sent by The Surgeon General on thirty days TDY to the Far East Command. The mission of the team was to

find out what the important surgical problems in the command were and to suggest means of studying them.

For the many who are interested in, and contributed so much to discussions of, problems in the field with the team, it is pertinent to summarize briefly some of the data submitted by the team which pertain to surgery.

METHODS:

1. To obtain a perspective of the important professional problems in the command, the autopsy protocols on battle casualties at the 406th Medical General Laboratory were reviewed.

2. A study was made to determine the lapse of time from wounding to arrival at various levels along the chain of evacuation.

3. Forward medical facilities, all of the Army hospitals in Korea, and six of the larger hospitals in Japan were visited. At each of these medical installations informal conferences were held to discuss the important professional problems confronting the medical officers.

RESULTS OF THE STUDY: MAJOR PROBLEMS:

1. Renal Shut-down: Renal shut-down uniformly is the most serious single unsolved problem in the management of the severely wounded. Discussions with medical officers in the hospitals visited, disclosed a minimum of 110 clinical cases have been encountered, resulting in death in all except five. Clinical impressions as to contributing causes were the more frequent occurrence in warm weather, in severe fatigue, in the presence of infection, and long time-lag between wounding and hospitalization.

The criteria used for the pathologic diagnosis of lower nephron nephrosis by the pathologists at the 406th Medical General Laboratory were:

a. Degeneration and regeneration of epithelial cells in the distal tubules.

b. Inflammatory reaction surrounding such tubules.

c. Presence of pigmented casts.

d. Gross appearance of the kidney - large, pale and swollen, with cortex more prominent than usual.

Using these criteria, the diagnosis was made in about one-third of the cases of battle casualties examined by the pathologists. This is not to be construed, however, as the primary cause of death in all these cases. In many, these findings were not considered of clinical importance and the cause of death was peritonitis, clostridial myositis, other infections, etc. But the study illustrates abundantly the important role lower nephron nephrosis plays in the outcome of the management of battle casualties.

Further study of this problem may be directed toward:

a. Clarification of the criteria for diagnosis.

b. Basic observations on hydration and dehydration in the wounded.

c. Determination of the importance of multiple transfusion, the age of blood, minor incompatibilities, the dose of anticoagulants.

d. Definitive renal function studies, fluid compartment, and biochemical changes in the earliest phase of this syndrome.

2. Wound Shock: Usually, traumatic shock is not a great problem. Ample supplies of whole blood have been available and no difficulties have been encountered. In nearly all units, however, seriously wounded cases occurred who failed to respond to usual resuscitative measures. Autopsies were not done ordinarily to determine the basic difficulties. It appeared that many of these patients had thoraco-abdominal or abdominal wounds, especially with intra and extra-peritoneal wounds of the colon.

Further research in the field on the complications associated with blood loss and blood replacement should be productive of useful information. More information concerning the role of peritonitis and other infections, of pulmonary and cerebral complications, of fat embolism and of other complications in traumatic shock would be helpful in the management of trauma.

3. Clostridial Myositis: In the Korean campaign, as in warfare of the past, clostridial myositis is an important disease. The infection occurs early after wounding and is encountered in forward areas rather than communication zone hospitals. When communication zone hospitals, however, operate as evacuation hospitals and receive casualties early, as occurred in the Korean campaign, the infection is frequently seen. The 118th Station Hospital received 43 and Osaka Army Hospital 35 cases of clostridial myositis during this period.

A research team might attempt to answer a number of questions regarding this disease. Some of these are:

a. What is the cause of death in clostridial myositis? Is it bacterial toxemia? Is it toxemia resulting from the breakdown of the chemical components of muscle?

b. What are the metabolic effects of this disease? Are there changes in the chemical composition of the blood which can be recognized? Are there effects upon the composition of the fluid compartments of the body?

c. What determines whether a patient will develop clostridial myositis or anaerobic cellulitis? Can immunologic differences hitherto undetected be uncovered by new techniques? Are the organisms different or are immunologic characteristics of the host different?

d. Can methods be devised for easier clinical differentiation between clostridial myositis and anaerobic cellulitis?

4. Other Infections: Debridement of wounds and early administration of antibiotics have minimized soft tissue suppuration. A large number of traumatic open wounds provides a wealth of material for bacteriologic and antibiotic sensitivity studies. Tokyo Army Hospital has such a project under investigation.

Acute peritonitis, secondary to gunshot wounds of the abdomen, while more prevalent in the early phase of the conflict, continues to be an important problem at this time. Further studies and evaluation of newer antibiotics in the treatment of peritonitis and the role of peritonitis in the production of extreme shock in patients with abdominal trauma, seems justified.

5. Craniocerebral and Spinal Cord Trauma: Autopsy protocols of battle casualties examined by the group disclosed death occurred in association with head trauma and brain abscess in about 30% of all cases coming to autopsy. These are weighed by the fact that only a small proportion of deaths resulting from battle injuries are autopsied and only those of special interest reach the laboratory. The combination of head trauma and encephalitis seemed particularly fatal.

More basic information is needed for such problems as:

a. Pathogenesis of traumatic small vessel thrombosis.

b. Sagittal sinus lacerations and their repair.

c. Management of paraplegics and methods for establishing bladder automaticity such as anterior sacral rhizotomy.

d. Development of synthetic substances for repair of dural defects.

e. Frequency of root pain in lesions of the cauda equina.

6. Transfusion of Blood: The flexibility of the blood supply program has been strained in the Korean conflict in an unprecedented fashion by rapid expansion of medical installations and the fluidity of the tactical situation.

There was variation in the maximum age of the blood used from 21 to 31 days and all units were careful to discard blood with gross hemolysis. None could correlate reactions with the age of blood used.

Accurate figures were not available on the quantity of blood actually used, incidence of reactions, cross-matching policy, number of units rejected by cross-match, and relationship of reaction or multiple transfusions to renal shutdown.

Suggested studies include:

- a. Better records on blood use and reaction.
- b. Studies on hemoglobin, potassium and glucose content of blood used in the command.
- c. Typing and Rh typing for reactions.
- d. Relationship of anemia to lack of cross-matching.

7. Debridement and Delayed Closure of Wounds: Because of the large number of battle casualties subjected to this principle of war surgery, this problem assumes major proportions. Early in the conflict inexperienced personnel closed wounds primarily in the hope that simultaneous antibiotic administration would favorably influence the results. Delay in wound healing and indeed clostridial myositis occurred from inadequate debridement and primary closure.

At the present time, the following principles are being advised:

- a. Do thorough primary debridement with secondary closure in four to seven days.
- b. The entire tract of a perforating wound should be debrided unless the risk of damage to important anatomical structures is greater than the calculated risk of severe wound infections.
- c. Antibiotics cannot replace good surgery in the care of wounds.

Problems which might be worthy of clinical research are methods of abdominal wall closure to reduce the incidence of significant infection and dehiscence and the relationship of bacterial flora and antibiotics to wound healing.

MINOR PROBLEMS:

Several minor problems exist for which more information might be useful to aid the doctor in the care of the injured.

- a. Hemothorax: The principle of repeated aspirations of hemothorax by needle and syringe has been advocated widely. There is still some confusion or lack of acceptance of this by some who believe intercostal tube drainage to be equal or superior to this method.

The thoracic team at the Tokyo Army Hospital found a greater number of complications following the use of rubber tube intercostal drainage than after needle aspiration. The thoracic team on the U.S. Hospital Ship "Repose", after studying 100 cases of traumatic hemothorax, concluded that those patients did best with multiple needle aspiration; those did next best who had prolonged intercostal tube drainage; and

those did worst who had intercostal tube drainage for only a short period of time.

Further data on this controversial subject should be gathered. Better records are required and a system of follow-up should be organized to aid in the study.

- b. Blood Vessel Injuries: These are being managed very well. There is need, however, for more accurate records, study, and follow-up of these cases if much is to come of this experience with vascular injuries.

- c. Thermal Burns: The Tokyo Army Hospital, in November 1950, began a study of the exposure method of treating thermal burns. This study has been correlated closely with similar study at Brooke Army Hospital.

The following is a brief resume of the results of all cases studied between 28 November 1950 and 15 June 1951:

165 CASES

CAUSES

51% Gasoline or oil
21% Open flame, hot stove or other objects
15% Steam, boiling water
13% White phosphorous

EXTENT AND DEPTH

59% - Partial thickness only

77% of these covered less than 10% surface
16% of these covered 10-20% surface
7% of these covered more than 20% surface

41% - Full thickness

72% less than 10% surface area
19% 10-20% surface area
9% more than 20% surface area

TIME ELAPSING BETWEEN BURN AND BEGINNING OF EXPOSURE

Mean for partial thickness - 5.5 days
Mean for full thickness - 6.2 days

TIME FOR HEALING OF PARTIAL THICKNESS BURNS

Average - 13 days

TIME BEFORE GRAFTING FULL THICKNESS BURNS

Average 19.2 days

DEATHS

None

It is believed that this project should be continued. Improvement in the treatment of burns is an important undertaking and the exposure method may be of considerable value in the management of mass burn casualties.

CONCLUSIONS OF THE TEAM:

Conservation of manpower for the fighting forces is the primary mission of the medical services. Research in the field must be secondary, but it is nevertheless invaluable to the advancement of medicine.

Clinical investigation may be conducted with little more than careful clinical observation, accurate and detailed records and good follow-up. Useful information may be obtained by this method in such entities as open wounds, thermal burns, rehabilitation, traumatic ocular lesions, traumatic hemothorax, wounds of the blood vessels and some medical diseases. This research cannot be carried out satisfactorily or entirely by individuals in "addition to their other duties." Expansion of the consulting staff, Medical Section, GHQ, to work with the medical officers in the field on such problems should prove of lasting benefit.

It should be feasible to observe patients from shortly after wounding through various stages of treatment, to later stages, keeping accurate records, attempting selected procedures and to evaluate results.

Laboratory investigation appears to be sufficiently important to aid in the better understanding of such

problems as lower nephron nephrosis, shock which fails to respond to the usual forms of treatment, clostridial myositis, transfusion of blood and various problems in general medicine.

Laboratory facilities and research personnel for biochemical and physiologic investigation could be established at the level of a mobile army surgical hospital where cases would be studied within six hours after wounding. Some observations could be made in more forward areas by assigning one or more members of a team to a collecting station, for example, for making preliminary observations, taking samples and injecting accepted test substances for study when the casualty reaches the forward laboratory. The investigators would be expected to "pull their weight" while attached to forward areas. The laboratory would be mobile; providing its own tentage, equipment, vehicles and supplies. Such a laboratory and its investigators could not fail to be a stimulus to the staff of the hospital to which it might be attached.

INFORMATION TO ASSIST HEPATITIS COMMISSION

The following radio message received in this Headquarters from the Department of the Army is published in its entirety as a matter of information for personnel concerned:

"1. In order to obtain information to assist Hepatitis Commission in its studies on the incidence of hepatitis among patients who received plasma, it is desired that instructions, essentially as given below, be issued to all medical units your command.

"2. In addition to the requirements set forth in Par 82, AR 40-1025, for recording on the individual medical records the fact of plasma transfusion, these will be recorded also, for the limited period of time stated below, the manufacturers name and the manufac-

turers lot number (including lettered prefix and/or suffix, if any) and the date of transfusion of the particular unit of plasma injected, for example:

21 Sep 51, plasma, 500 cc: Upjohn Lot 40362 A.

The manufacturers name and the lot number are given on the instruction label affixed to the bottle of processed plasma and also on the label on the plasma box.

"3. These additional reporting instructions become effective 15 Sep 51 and continue for 6 months through 15 Mar 52, at the expiration of which time these separate instructions become void."

HEMATOLOGIC CHANGES IN SMALLPOX

Lt (jg) Julian B. Hyman, MC; Capt Sigurd Sivertson, MC, 3rd Station Hospital, APO 301

Twenty-one cases of smallpox have been followed carefully at the 3rd Station Hospital from October 1950 through May 1951 both from a laboratory and clinical point of view. In this series there were 11 cases of variola major and 9 cases of variola minor. One case of hemorrhagic smallpox was also included in this group. Eight of the 21 patients died. The literature reviewed reveals only a minimal amount of information concerning the blood count in this disease. According to previous work the count early in the course of the disease revealed a leukocytosis with a predominance in polymorphonuclear leukocytes. During the maculopapular stage of the disease the count usually returned to normal or a slight leukopenia developed and during the vesicular and pustular stage of smallpox there was a marked leukocytosis with counts up to 30,000 white blood cells per cubic centimeter, and a definite increase in neutrophils. In hemorrhagic smallpox there was a thrombocytopenia, a leukocytosis and a lymphocytosis. Counts in hemorrhagic smallpox have been reported up to 70 to 100,000 white blood cells per cubic centimeter.

In our series of cases we found that during the early

stage from the first through about the 8th day, a slight leukocytosis existed with an increase in neutrophils. However, during the maculopapular stage and up to the onset of the vesicular stage the leukocytosis persisted with a relative lymphocytosis present. When the disease reached its crucial period, about the 13th or 14th day of illness, in addition to the persistent leukocytosis the patient developed an absolute lymphocytosis. The criteria for this was a lymphocyte count of more than 3500/cu. cm. In fatal cases a different pattern evolved. At the onset the picture was the same, that of a leukocytosis and increase in neutrophils. During the maculopapular stage this picture persisted and as these people reached the critical period and entered into the vesicular stage a relative lymphocytosis failed to develop. In the exceptional case where there was a relative lymphocytosis present, a falling total lymphocyte count instead of a rising total lymphocyte count was noted as the crucial period appeared. The crucial day appeared to be the 14th day of illness. The majority of deaths occurred at this time. In the cases that recovered the leukocytosis and lymphocytosis would persist sometimes as long as the

28th day after the onset of illness. In some cases the total white blood count and differential would return to normal earlier than this. Our one case of hemorrhagic smallpox had the picture that was previously described for this form of the disease. There was a thrombocytopenia, a leukocytosis and a lymphocytosis. The total white blood cell count was over 30,000 per cubic centimeter.

In addition to the alterations in the total white count and total lymphocyte count there were also definite qualitative changes recorded in the lymphocyte series. There was a marked variability of lymphocytes noted with at least four distinct types of lymphocytes readily identifiable. This was also true of the case of hemorrhagic smallpox and was seen in all of our cases regardless of the severity or mildness of the particular case. Most predominant amongst these cell types was a large cell with about five times the normal cell diameter of a lymphocyte, with a sky blue cytoplasm, a vacuole adjacent to a bean shaped nucleus, a hyperchromatic type of nucleus and prominent azurephilic granules in the cytoplasm. Many young lymphocytes were noted. The granulocyte series showed some interesting changes also. Twelve of the 21 cases exhibited a definite shift to the left. A shift was defined as the presence of granulocytes at the myelocytic stage or younger. Six of the 12 with this change in the granulocytic series died and 6 recovered. Five

bone marrow examinations were performed, all five being done in fatal cases. These marrows revealed a definite myeloid hyperplasia with a shift to the left. In all five there was a definite increase in myeloblasts, promyelocytes and myelocytes.

We feel that in all probability the pattern that we noted represents the true response of the hemato-poietic system to smallpox. All of our patients were treated with antibiotics and as a result the pustular stage of the disease was aborted. In contrast to this, the previous hematologic findings reported were being masked by secondary and intercurrent infections.

In conclusion, a brief summary of the blood changes found in 21 cases of smallpox has been presented. One of the most outstanding changes has been the presence of an absolute lymphocytosis in non-fatal cases when the critical stage of the disease approaches. In fatal cases a persistent leukocytosis and increase in neutrophils was noted. The presence of an absolute lymphocytosis appeared to be a definite sign of good prognostic import. We also noted a marked qualitative change in the lymphocytic series and a shift to the left in the granulocytic series. We feel that the blood findings described in this series can be of definite value in determining the prognostic outcome of a case of smallpox and may also be of diagnostic aid in this disease.

BACTERIOLOGICAL USE OF SCREW-CAPPED TUBES

Information received from the Chief, Pathology and Allied Sciences Section, Surgeon General's Office, indicates that certain precautions must be taken in the bacteriologic use of screw-capped tubes. The use of various containers of this type in bacteriologic laboratories is rapidly increasing. Two important measures, mentioned in recent literature and apparently not too widely known, are called to the attention of laboratory personnel.

1. The plastic caps should never be cleansed with, or placed in, solutions of cresol or alcohol. After such treatment, phenolic compounds may be released in sufficient concentration to inhibit growth of

organisms (Brandon and Levin, Public Health Laboratory 9:31 (Mar 1951)).

2. In the universally used Kliger's or Triple Sugar Agar fermentation tests, the tubes should be incubated with loose caps after inoculating. If air exchange is not permitted, reactions on the surface of the media are obtained which are identical with those deep in the agar, and misleading results are thus obtained. The caps should be loosened for sterilization, tightened after cooling, and replaced only loosely after inoculation. This should be done with all but anaerobic media.



ASTHMA

Colonel Edward A. Cleve, MC, Chief, Medical Service, Tokyo Army Hospital

The present conception of the mechanism in an allergic reaction is based on the belief that a specific antigen-sensitized cell reaction results in the release of histamine, or a histamine-like substance, in a hypersensitive individual. This broad conception includes both the

immediate or wheal type and a delayed or tuberculin type.

The relative roles of bronchospasm, edema of bronchial mucosa, and hypersecretion in an attack of asthma are not clear. Necropsy findings show all three factors to be present in varying degrees in each case. Clinical studies indicate that they may

vary according to type and duration of the asthma. The hypersecretions and the thick tenacious secretions certainly are important in the status asthmaticus, although some authors feel that asthma is primarily produced by constriction of the bronchioles throughout the entire lung field with edema of the mucous lining and an outpouring of a thick tenacious mucoid secretion. The bronchospasm has been observed through the bronchoscope and by means of lipiodol studies of the tracheo-bronchial tree.

The bronchiolar musculature is controlled by the autonomic nervous system, the sympathetic or thoracolumbar division of which serves as the dilator supply and is the dominating influence, normally, over the constrictor parasympathetic or craniosacral division of the autonomic system. This situation, of course, results in a marked lowering of the vital capacity to the dyspneic point and the patient is in

as much distress as the cardiac. Indeed, the mechanism by which dyspnea is produced is comparable, in that it is the vagal reflexes inaugurated by this inelastic lung which affect the respiratory center so as to produce tachypnea and dyspnea. (Experimentally, Harrison has shown that sectioning of the vagi in an inelastic lung markedly decreases or abolishes the dyspnea.)

In order to reverse the sequence of events just described, we resort to the use of a powerful sympathomimetic drug, epinephrine, whose action stimulates the sympathetics, resulting in a dilatation of the bronchioles and a vasoconstriction of the blood supply to the bronchial mucosa. This accomplishes a free access of air and a diminution of the mucous plug. By so returning the lung to its normal elasticity, the vital capacity returns to normal and the dyspnea is abolished.

In asthmatics there are two factors at play, one emotional and the other sensitizing. Unquestionably, emotional disturbances frequently precipitate asthmatic attacks, but in my opinion they are rarely the sole cause of the disease. Anxiety and fear of suffocation commonly aggravate severe asthma, while in the initial states of asthma acute fear of suffocation and loss of the mother or mother substitute are common precipitating factors. Desire for the attention gained by the asthmatic attack is sometimes of considerable importance. In some cases the emotional factor can be almost entirely responsible, and in a few others the sensitizing factor alone is decisive; but, in most instances, there is a combination of these two influences. Where symptoms are purely emotional in character, one would think them indicative primarily of pseudo-asthma, such as is seen in hyperventilation syndrome.

In allergy a more conservative note is necessary because of the relation of emotions to skin and other diseases and the effect of allergy on child behavior. For example, Arthur J. Horeish said that allergy in children includes more than hay fever, asthma, eczema, and hives. The allergic infant has nursing difficulties, colic, diarrhea, and vomits easily. Formulas that agree with him are difficult to find. Eczema may develop from the foods to which he is allergic, and colic and bronchitis are common. Not infrequently such children present behavior problems and it is unwise to believe that the child will outgrow this trouble. Early treatment is essential.

Respiratory allergy -- particularly the immediate wheal reaction group below the age of 30 -- is relatively common, with an incidence of 1% to 3% of the general population. Where there is bilateral antecedent allergic history, approximately 75% of all children develop spontaneous allergies before the age of five, while in the unilateral history only approximately 50% would have symptoms. In a unilateral antecedent history the maximum incidence is between 10 and 15 years in the offspring. If there is no antecedent history in the family, the occurrence of symptoms is about the age of 30. Certainly in the present stage of eugenics, until we discourage the intermarriage of allergic persons, little can be accomplished in preventing the transmission by inheritance of the tendency to become sensitized. Nor can we prevent the capacity to become allergic.

Characteristically, the symptoms of asthma are dyspnea, wheezing, coughing, and at the end of the attack, expectoration which varies both in severity and duration. The patient assumes a hunchback or garboyle position with the maximum use of the costal

muscles involved. There is marked difficulty in both the inspiratory and expiratory phases of respiration, but the expiratory phase is attended by the most distress. On auscultation there are numerous wheezing, sibilant, and sonorous rales heard throughout the chest, with the expiratory phase definitely prolonged over the inspiratory phase.

Laboratory findings: The blood characteristically shows an increase in eosinophils which may range from five to fifty per cent of the differential count. This is a common finding in asthma. Early in the attack there may be very little sputum, but at termination expectoration of tenacious sputum plugs characteristically showing Charcot-Leyden crystals and eosinophils occurs. The urine and blood chemistry are essentially normal. The electrocardiogram during an attack usually shows variation from normal which is difficult to interpret but which reverts to normal when the attack is over. In acute attacks the tracing may reveal characteristics of acute coronary. However, for accurate evaluation it is advisable to take electrocardiograms after, rather than during an acute attack. X-ray and fluoroscopy of the chest do not reveal any findings in uncomplicated asthma. Fluoroscopic findings during an acute attack show emphysema with depressed diaphragm. The heart is normal or decreased in size.

Every case that presents wheezing is not asthma. One must differentiate asthma from such conditions as paroxysmal, nocturnal dyspnea of cardiac disease, or cardiac asthma, mediastinal tumor, pulmonary tuberculosis, pressure in the chest from aneurysm or foreign body, bronchogenic carcinoma of the lung, chronic bronchitis, chronic emphysema, cor pulmonale, chronic glomerulonephritis, substernal thyroid, hyperventilation syndrome, and enlarged mediastinal lymph nodes. In many instances it is most difficult to separate these conditions. A history and physical examination with the necessary laboratory findings are very useful.

A good working classification divides asthmatics into two general groups: The first group has its onset before the age of 30 and the second group after the age of 40.

Let us first consider asthma before the age of 30. This group consists of cases with frankly extrinsic causes, in whom there is immediate wheal reaction and usually a definite familial antecedent.

Seasonal inhalants: The tree pollen season is usually short, depending somewhat upon the season of the year as to its occurrence. An early spring means early pollination; late spring, late pollination which lasts nearly ten days to two weeks. The grass pollens begin about the end of May and last until the early part of July, except for the plantain which begins somewhat earlier and lasts until later. Ragweed or weed season begins between the 15th of August and the 1st of September and lasts until frost. Of all the seasonal antigens, ragweed is the most important as it occurs late in the fall when upper respiratory infections are unknown, and after the mucosa is sensitized to ragweed it is somewhat easier later to sensitize it to bacterial infection.

Molds play very little part in asthma in the U. S., but are probably significant in the tropics, occurring usually in the rainy season but somewhat throughout the year.

Asthma induced by insects has a short seasonal incidence. A typical example is the caddis fly, which

is quite prevalent during the month of August in the Great Lakes area.

Non-Seasonal Inhalants: Of the non-seasonal inhalants, house dust is important. It contains lint from wool, silk, kapok, cotton, and linen; wisps of feathers from bedding and upholstery; and danders, if there are pets in the house. Industrial dusts are particularly significant in the history of bakers, millers and brewers, and sometimes produce severe asthma. Animal danders (desquamated epithelium) commonly derive from household pets, such as dogs, cats, and from horses; etc., as well as from the furs or cheap matting (cow hair and dander) under the rugs. A common cause of asthma is the feathers (goose, chicken) contained in pillows; also cheap furs for children, usually rabbit fur. Glue can cause very severe asthma. Orris root contained in face powder is not the severe problem it formerly was. One may glean these significant points from the patient's history.

In adults, foods do not produce any great incidence of asthma. There are certain foods which can be incriminated more often than others, such as fish, eggs, milk, wheat, tomatoes, beef, and chicken. One must be careful in the use of buckwheat and mustard seed antigens, as a rather severe skin reaction may result in sensitive individuals. Drugs do produce by ingestion severe attacks of asthma, but fortunately, only relatively few patients have such reactions. This information concerning drug sensitivity can usually be supplied only from the patient's history. When an asthmatic states definitely that a drug produces attacks, one should take this at its face value and not attempt to prove the point.

Infective agents are the virable types of antigen, which are continuously produced in the body. Asthma is frequently seen in children and young adults after an acute infection such as pneumonia, scarlet fever, etc.

Contacts and injections play very little part. Penicillin rarely on injection produces asthma. A typical example of contact is the application of mustard plaster on a sore back with production of asthma.

A carefully detailed detective type of history is essential prior to skin testing the patient. This will reduce to a minimum the anaphylactic reaction and possible fatalities. For example, if there is a history of asthma upon exposure to the odor of eggs, one must be careful to use very dilute material in testing. Often the individual will react with a skin sensitivity when the antigen is not the one producing the symptoms, as in a patient who has ragweed hypersensitivity with asthma but whose skin reacts to both ragweed and timothy. It is not necessary to treat him for timothy as he has no symptoms during the period of timothy pollination. Further, city dwellers who are not exposed to horses and farm animals need not be hyposensitized to them. In testing cases, it is important to make not only a cutaneous or scratch test, but also intradermal and even passive transfer tests in order to determine the factor involved. When all tests are negative, one can place the case in Group II. An allergist can practically abandon the scratch test which does not produce as many definite reactions, and use only the intradermal test, especially in testing food allergies as such antigens are not very potent. One must be extremely cautious in testing intradermally with cottonseed, linseed, kapok, and fish extracts in very sensitive individuals, since alarming and even fatal systemic reactions have occurred. A close correlation must be made of the history and skin tests, and treatment must be based on the history.

An excellent method in intradermal tests for the trees and grasses and ragweed is to use dilutions of each material in three strengths: 1 to 10,000; 1 to 1,000; 1 to 100. The wheal and erythema reaction produced is then measured and particular note made of the presence of any pseudopods. Such observations are quite helpful when plant hypo- or desensitization is to be attempted. If the patient has a marked reaction to the 1 to 10,000 dilution, the allergist must be certain to proceed in his treatment with caution.

The type of treatment that the allergic patient requires will depend upon the results of appropriate diagnostic studies. If a specific cause or causes have been revealed it is better, if possible, to eliminate these factors completely without resort to desensitization. Control of environmental factors for the relief of asthma is the therapy of choice. In certain cases it is an excellent idea to hospitalize the patient or to have him take a vacation to determine what effect a change in environment will have on the asthmatic attacks. It is better to eliminate the antigen unless one's occupation involves exposure to the antigen and cannot be changed. A horse trainer or a baker should, if possible, change his occupation as it is quite difficult to desensitize individuals. One doesn't use feathers as an antigen, but covers the pillow instead.

If, in the history of the household, dust is incriminated, it should be eliminated by use of a wet mop or vacuum cleaner instead of a broom; thick rugs should be removed from the bedroom floors, pictures from the walls, and heavy drapes from the windows. By this means much of the exposure to dust in the bedroom may be eliminated. When inhalant factors and antigens cannot be completely avoided such as house dust, ragweed, and grasses, one may proceed with a schedule of hypo- or desensitization of the individual. Often a visit to the home by the physician to search out these conditions will be fruitful.

Offending foods must be eliminated from the diet but one should be certain that these are actually the foods which have produced the asthma. Otherwise, all foods may be incriminated, creating a food faddist. If certain foods such as strawberries cause asthma each time the individual has strawberries, symptoms must be produced. A good practice is to have symptoms produced at least three times before eliminating a food. In the use of potent antigen, one has a two-edged sword. One may very easily be using too powerful an antigen, and too frequently produce the very symptoms that one wants to eliminate. Even the author is guilty of this experience. Often when the treatment is stopped, symptoms will lessen. It is most difficult to hyposensitize an individual; it requires a number of years, especially with the use of dust.

Asthma after the age of 40 usually has a negative antecedent history of allergy, often no past history of allergy or, if present, it is vague and the intradermal skin tests are quite uniformly negative, but if positive they cannot be readily related to asthmatic attacks.

In this group of patients, change in environment, diet or weather have no influence on their asthma. The asthma is usually severe and may even be rapidly fatal. Example: A 55-year old male admitted to Guam with no previous allergy history had severe asthma shortly after his arrival there which proved fatal in less than one month. Pathologically, there seems to be more secretion in the bronchi and less spasm than in the frankly allergic group. Infection may also be

present in the paranasal sinuses, bronchi, teeth, and complications of bronchiectasis and emphysema seem to follow early. There are many theories as to etiology of asthma in these cases, but perhaps most plausible is infection with delayed type of skin reaction. The first step in treatment is to be sure the patient belongs in this group and not in the immediate wheal reaction group, as occasionally a patient will develop asthma after 40; for example, a druggist who after age 50 became sensitized to aloes and elimination of the agent resulted in complete elimination of symptoms. In this group control of sinusitis and nasal infections by proper local and systemic means is in order. The results of vaccine therapy remains a controversial issue. Some workers claim good results with autogenous vaccine and others equally good results with stock vaccine. At times when too large dosage of stock vaccine is used, asthmatic attacks may be prolonged.

A selected group of cases are those associated with hyper-plastic sinusitis and later asthma. The antecedent history dates back many years with a perennial rhinitis associated with nasal polyps and sinuses. One must, from a practical standpoint, treat these patients prior to their development of asthma by both surgical means and hyposensitization. Surgery directed toward mechanical and physiological improvement of the nasal cavities and toward lessening sinusitis in the antrum, ethmoid, and sphenoid sinuses offers less risk of a poor local result in the nose and sinuses and probably better chance for improvement in allergic rhinitis than more radical procedures. Cooke, in his summary of cases with combination of surgical removal of injected sinuses with autogenous vaccine, demonstrated an improvement in approximately 70% of his cases -- especially in those between the ages of 21 and 35 with symptoms of less than five years' duration.

Great caution must be exercised in using drugs in asthma since many patients are sensitive to drug compounds such as aspirin, phenobarbital, morphine, etc. Unfortunately, these complex chemicals do not produce reactions to the skin and the only way to determine sensitivity to them is to use them, but this is not always a safe procedure. Aspirin is known to produce severe reactions and even death. Use no drug in treatment of asthma if patient is insistent he is allergic to it. It is far safer to use those drugs having simple chemical formulae, such as bromides, chloral hydrates and paraldehydes.

Equally effective methods are olive oil and ether as a retention enema. An old-fashioned remedy of ipecac to the point of emesis is quite effective, especially in children. Sodium iodide, after one is sure the patient is not sensitive to it either by mouth or intravenously, is effective, especially in the elimination of the tenacious sputum. Mild cases are adequately treated with phenobarbital and ephedrine orally. A useful prescription is an eighth grain of phenobarbital and three-eighths grain of epinephrine. Morphine sulfate is mentioned only to be condemned as it is a respiratory center depressant. A number of deaths have followed the use of morphine, possibly directly attributable to it. An amidone derivative preparation such as dolophine may prove to be a safe drug. In severely dehydrated patients one may get valuable relief by the use of glucose in normal saline intravenously. If signs of cardiac failure appear, one must treat in the usual manner. Therapy for acute and mild attacks can be controlled quite successfully by using small doses of epinephrine hydrochloride, 1 to

1,000 dilution, 0.2 cc or 0.3 cc. With this low dosage there are few side effects such as pallor and rapid heart action. This dose may be repeated every 20 to 30 minutes three or four times, or until relief is afforded. Another method is to use this same solution as an inhalant. The incorporation of this material in a slowly absorbing vehicle such as peanut oil or gelatin can be used effectively but one must be careful that the vehicle is not producing symptoms. An old grandmother's remedy of stramonium smoked as cigarettes or in powder produces prompt relief sometimes. Aminophylline intravenously twice daily, dosage 0.5 gms for 3-5 days is quite effective. Later it is given rectally by suppositories. Once the attack is controlled epinephrine may be given for the milder wheezing.

Status Asthmaticus: This special group, with severe symptoms, can usually be considered as occurring after the age of 40, which comprises those cases in which infection in the paranasal sinuses and bronchial tubes is present and immediate skin reaction negative. However, any asthmatic can lapse into a persistent uncontrollable wheezing, coughing and dyspnea. Frequently the injudicious use of epinephrine by inhalation or injection may aid in the production of this state. The symptoms are due to the tenacious bronchial plugs which cannot be dislodged. In a few instances, a bronchoscopy performed with suction, removing the plugs, can be life-saving. In these severe cases I have followed successfully a course as outlined by Barash, who gives by inhalation a mixture of 20% oxygen and 80% helium by means of the BLB mask. The low specific gravity of this mixture allows the gas to penetrate through the obstructed bronchi. It should be inhaled for as long as 3-4 hours at one time, if necessary, or even longer. Sedation is most useful, using phenobarbital and amytal in fairly heavy doses in stopping an attack.

Asthma is in the list of diseases in which Thorn finds ACTH therapy most useful. It is the adrenocorticotrophic hormone of the pituitary which stimulates the adrenal cortex -- that is, all of the hormones of the adrenal cortex including cortisone. A number of authors have shown rather dramatic response in severe asthma with the use of this hormone in the dosage of 25-30 mgs. initially with 25 mgs each six hours. The asthma promptly improved and usually cleared, although some recurred. In some of these cases nasal polyps existed and improved when treated with ACTH; a few even disappeared. ACTH may be an essential link in the "alarm reaction" of Selye, or connected also with Rackemann's "depletion theory." Cortisone is one of the eleven oxysteroids of the "N" hormone of Kendall. When this hormone is used in large doses it depresses the function of the adrenal cortex. Reiter demonstrated in rats a definite decrease in size and weight of the adrenal cortex. It is the author's opinion that cortisone is not a useful drug for asthma due to its depressant effect on the adrenal cortex. Symptoms would disappear with this treatment in severe asthma but probably would recur immediately on cessation and, in some instances, in a more severe form.

In the treatment of allergic patients, one must treat the entire life situation including both the emotional and tension factors and the antigen factors. If this is done, the results are better. In treating these patients one must be certain not to over-treat as the use of the antigen itself may produce symptoms. When cases are not doing well, it is at times better to stop all treatment.



BOARDS, CERTIFICATES, AND PSYCHIATRIC REPORTS (1)

Colonel Donald B. Peterson, MC, Consultants Division, Medical Section, GHQ, FEC

This article consists of a series of comments on implementation of regulations which are interrelated because they have as a common denominator the vagaries of human behavior. In one way or another these vagaries affect all members of the Armed Forces, and create a major problem to the military medical officer. Although the following is written as an aid to the Army psychiatrist in a general hospital, and may be used in cookbook fashion in the handling of specific problems, careful perusal will reveal a philosophic continuum from which attitudes and concepts may be derived which enable any Army medical officer to see and act in accordance with the principle behind the regulation. In extreme cases, medical officers have

been known to take pleasure from the execution of a clear, logical, well-planned bit of paper work. The subject matter is timely because of the expansion of the Armed Forces and the influx of young doctors whose military and forensic training is only starting.

The psychiatrist is concerned primarily with the care of the sick. It is possible to accomplish this primary mission only if proper administrative procedure is carried out accurately and expeditiously. Because much administration is directly involved with boards, certificates, and reports dealing with the sanity, personality, or other mental, emotional, and behavioral attributes of patients, a thorough and practical understanding of such procedures is prerequisite

(1)As modified from original paper, of same title, U. S. Armed Forces Medical Journal, 2:6, 959-970, June, 1951

TABLE 1. - Publications frequently used

Code Number	Title	Remarks
AR 420-5, 20 May 40	Boards of Officers for Conducting Investigations	General rules and procedures for boards, investigations, and taking of evidence.
TM 8-240, Sep 50) AFM 160-42)	Psychiatry in Military Law	
MCM, 1951	Manual for Courts-Martial, U.S., 1951	Chapter 24, par. 120-124, Insanity
SR 600-500-5, 29 Apr 49) AFR 160-24)	Personnel - Psychiatric Evaluation Prior to Referral to Boards	
AR 600-450, 7 Nov 49) AFR 39-11)	Personnel - Separation for Physical Disability	Medical boards and physical evaluation boards.
SR 600-440-1, 7 Jun 49	Personnel - Disposition of the Psychotic	Including general prisoners.
SR 615-360-40, 25 Aug 50) AF PMP-4H 3 & 211)	Enlisted Personnel - Disposition of Individuals with Physical or Mental disability	Discussion of administrative elimination of enlisted personnel and authority for acceptance of resignation of enlisted personnel with existing prior to service (EPTS) physical disability
AR 615-366, 26 Oct 49) AFR 39-21 and) AFR 39-23)	Enlisted Personnel - Misconduct, Fraudulent Entry, Absent Without Leave, Desertion, Conviction by Civil Court	Par. 9 - physically unfit deserters and absentees; par. 2h - fraud, concealment of physical defects.
AR 600-443, 12 Jan 50) AFR 35-66)	Personnel - Separation of Homosexuals	
AR 615-368, 27 Oct 48) AFR 39-17)	Enlisted Personnel - Discharge, Unfitness	
AR 615-369, 27 Oct 48) AFR 39-16)	Enlisted Personnel - Discharge, Inaptitude or Unsuitability	
AR 345-415, 14 Aug 45	Military Records - Daily Sick Report	Investigation of line of duty
AR 605-200, 26 Jan 51) AFR 36-2	Officers - Demotion and Elimination	
AR 40-590, 21 Jan 46	Medical Service - Administration of Hospitals, General Provisions	Authorizes the commanding officer of a hospital to appoint a disposition board to advise him in such cases as he considers necessary.

FITZSIMONS GENERAL HOSPITAL
DENVER, COLORADO

CERTIFICATE

.....

I certify that this is the report of neuropsychiatric examination in the case of

Grade	Name	ASN	Organization
who was admitted to this hospital on.....; and that after careful examination the diagnosis is found to be:			

(Use same code number and nomenclature as given in Final Summary and on Form 55a)

Pertinent History:

Mental Status:

This condition is characterized by:

In my opinion the soldier was and is mentally responsible, both to distinguish right from wrong and to adhere to the right.

This condition is not amenable to hospitalization, treatment disciplinary action, training, transfer to another station or organization, or reclassification to another type of duty. There are no disqualifying mental or physical disease or defects sufficient to warrant discharge under the provisions of AR 600-450 or other disposition through medical channels.

Recommendation: That this soldier be continued on duty until command decision is reached as to whether or not he should be retained in the Service. In the event that his performance is such that he is deemed to be useless to the Service, the soldier should be separated from the Military Service under the provisions of AR 615-36 because of

.....

MC

Neuropsychiatrist

Figure 1.

to the successful practice of psychiatry in the Army.

The publications listed in table 1 are part of the working knowledge of the Army psychiatrist.

Boards, certificates, and reports are similar in that their function is to provide specified information to certain persons under certain circumstances. Just what information is to be provided and to whom it should be directed may be specified, or these may be implicit in the circumstances. For example, an untried prisoner may be referred specifically for action under par. 121, Manual for Courts-Martial (MCM). Usually, however, he is just sent to the hospital for mental observation. This circumstance implies referral and authorizes taking action under par. 121, MCM. It would be uneconomical to enter into correspondence with the unit commander merely to get a formal affirmation of what is already intrinsically authorized by the circumstances.

A report is an informal document without legal standing. It is useful to convey information in any case in which there is no possibility that evidence is required.

A certificate by an officer is similar to an affidavit in that an officer puts himself under oath by the act of signing a certificate. He makes himself responsible for the truth of the document. Any document becomes a certificate when an officer signs a statement containing the words, "I certify....". A certificate is usually admissible as evidence to a board such as convened under AR 615-368, but not to a court martial. Often the brief clinical history of an AR 600-450 board is certified in the event that the board and certificate may be used in evidence by other boards, such as those convened under AR 615-368 or in court martial investigations. Although under certain circumstances a certificate is useless as evidence because it is not "best evidence," it is useful in relation to command action. For example, although a court cannot take cognizance of a certificate, the certificate often is instrumental in determining whether the accused is to be tried or not.

Boards are authorized by various regulations and their purpose may be specific or general, depending on the regulation. They are convened to give command authority the benefit of the mature, considered, expert, and informed judgment of experienced officers. The use of boards is an attempt to give command a complete and accurate report on which to base a decision. In most cases, great latitude is given the board in making findings and recommendations so that the broad purposes of any board are well served.

Mechanics and elements: - The formality of the document is greatest in the board, least in a report, and within each type of document varies with the regulation, purpose, and ground rules of the command. In general the following features and headings are standard (fig. 1): (1) heading which includes the title of the document, the authorizing regulation and the date, (2) the diagnosis, (3) pertinent history, (4) expert interpretation of the diagnosis, presenting the salient features in nontechnical terms, (5) findings, (6) comment which is optional but useful in arriving at recommendations (7) recommendations, and (8) signature with title because the title indicates the role of the psychiatrist concerning the particular case rather than his duty designation of ward officer.

Almost all board reports are submitted on WD AGO

Form 8-118. This form is required for AR 600-450 boards, and is convenient for other boards. With this exception no printed form is necessary. The whole board proceedings may be typed on blank paper. All copies of board proceedings are signed by all members except the AR 600-450 and AR 40-590 boards in which the original is signed and the first copy initialed by only the president and recorded. All copies, including file copies, of certificates must be signed. An unsigned document labeled "certificate" is not a certificate and is without value. Further findings not covered by the form are made as necessary and any inapplicable findings printed on the form are labeled DNA (does not apply).

To fulfill their purposes these documents must be clear and logical, and the reasoning involved must be intelligible to the layman. The diagnosis and its interpretation must be backed up by the history, and the findings must support the recommendations. Further, these documents must be legible. Because from 6 to 8 copies are often required, if at all possible, the original should be on onionskin paper. Such paper can be mimeographed if a sheet of mimeograph paper is inserted between each printed sheet to come off the roller. People may resent this extra effort and may even claim it is impossible, but the medical effort is wasted if the document is illegible. In the preparation of copies of forms, care must be taken that the forms are in register during typing. All this is obvious but nonetheless often becomes a major problem. The various regulations specify the elements that are essential to make findings and recommendations for positive action. Unless these elements exist and are recorded in the document, the whole effort is ineffective and wasted.

ACTION REQUIRED PURSUANT TO SPECIFIC REGULATIONS:

AR 600-450: With certain exceptions military personnel are separated through medical channels when unfit for further duty by reason of physical or mental disability. Disorders such as pathologic personality, character and behavior disorders, immaturity reactions, and mental deficiency are considered to be personality variations rather than diseases. If a patient has a psychosis (see SR 600-440-1), the board will make the following findings: (1) diagnosis; (2) whether or not he can be released from military control without danger to himself or others; (3) whether or not he has the mental capacity to understand the nature of the board proceedings and to conduct or cooperate in them; (4) that he has attained maximum benefit from military hospitalization; (5) whether he should be discharged into his own care, the custody of his family, or to another hospital; (6) how many attendants, if any, will be required when he is transferred from the hospital; and (7) such other pertinent findings as his ability to distinguish right from wrong and to adhere to the right are required when some offense is alleged.

The AR 600-450 board, i.e., the "medical board," is in general similar to the old AR 40-590 disposition board, in that recommendations of referral to Physical Evaluation Boards, to boards convened under AR 615-368, AR 615-369, or AR 605-200, may be made as well as recommendations of return to duty, with or without limitations. Many patients reach a general hospital who perhaps would not, if the referring hospital were more liberally staffed psychiatrically. The patient may have exaggerated some trifling complaint in an effort to avoid duty. The patient's physical condition often does not warrant a medical board but the circumstances may call for it. In case

of doubt it is well to hold a formal medical board or an AR 40-590 disposition board, since such action becomes a matter of permanent record and carries more weight than the fact that the patient was hospitalized and the ward officer returned him to duty. The board report becomes a part of the Field 201 file and those who must deal with the patient on duty have a right to know the result of the medical deliberations. Conversely, care must be exercised to see that the material in the brief clinical history is material and relevant, and that personal material that is inconsequential to the issue be kept out of this record of patients returned to duty. Suitable accompanying papers or exhibits may be necessary, e.g., if a recommendation is made for Veterans' Administration or state hospitalization or discharge to relatives, a 10-P-10, authorization from the state, or acceptance from the relative is necessary. A brief clinical history is always required.

SR 600-440-1, par. 9. (Disposition of general prisoners): The findings and recommendations required of boards convened under this regulation are explicitly stated therein and will not be repeated here. An SR 600-440-1 and AR 40-590 board must be accomplished at least 60 days prior to expiration of sentence. If this is impracticable, the reason for delay must accompany the board.

SR 615-360-40 permits persons unfit for military service because of physical or mental disability which existed prior to service and was not aggravated by service to submit application for discharge for the convenience of the government and presents a discussion of administrative elimination of enlisted personnel. Similar procedure is authorized for Air Force patients per authority of AFR 39-14 and AF PMP-4H 3 & 211. A medical board held in such cases must make the following findings: (1) diagnosis, (2) that the condition existed prior to entrance on present period of active service, (3) that the condition was not incurred in line of duty during a prior period of active service, (4) that the condition has not been aggravated during prior or present service and (5) that the soldier has submitted his request for discharge. If all these findings can be made, a recommendation for discharge for convenience of the government is indicated; otherwise the recommendation should refer him to a Physical Evaluation Board. The application for discharge is submitted with the board proceedings.

Manual of Courts-Martial, U.S. 1951, par. 121 and 122c: Psychiatric examination with a view to aiding in the determination of mental responsibility, psychologic factors, mitigating circumstances of offenses, and with a view toward making recommendations to command authority regarding disposition in accord with the best interests of both the soldier and the government is authorized by the MCM, TM 8-240, and custom. MCM, par. 121, refers to pretrial psychiatric examination.

Although MCM par. 121 and 122c refer to a board of one or more medical officers and to the period between the preferring of charges and the approval of a sentence, it is customary for commanders to refer offenders for mental examination before charges are preferred. In such cases, ordinarily a certificate is executed rather than a board. Although an extremely brief certificate may fulfil the formal requirement, it must be remembered that in each such case, the psychiatrist becomes available to testify in person. Therefore it is best that the certificate be concise, rather than brief, and contain sufficient material to refresh his memory in the event he must

testify in person. At a large army hospital, even in routine pretrial clearances and especially where inpatients are concerned, the tendency is to hold a formal board, since this procedure seems more considerate and thoughtful and more in keeping with the time and effort already expended on the patient.

Separate and distinct coverage must be given the three "sanity findings":

1. Was the accused at the time of the alleged offense so far free from mental defect, disease, or derangement as to be able to distinguish right from wrong concerning the particular acts charged?
2. Was the accused at the time of the alleged offense so far free from mental defect, disease, or derangement as to be able to adhere to the right concerning the particular acts charged? and
3. Does the accused possess sufficient mental capacity to understand the nature of the proceedings against him and to conduct or cooperate intelligently in his defense? It must be remembered that if the soldier is not under charges, he is not "the accused," but is to be referred to as "the individual" or "the soldier."

Recommendations from the psychiatric point of view suitable to the situation are made with consideration for the best interests of both the soldier and the service. Comment is often made as to whether or not a "bar to trial by reason of insanity" is believed to exist. The recommendation may be "none." Often there is little to be accomplished by trial, and a recommendation for administrative separation is indicated.

AR 615-366, par. 9 authorizes the administrative separation of physically unfit deserters and absentees. No board is required, though such disposition may be recommended by a board. Deserters and absentees who are permanently incapacitated by medical or surgical conditions, or by "mental deficiency or constitutional psychopathy who obviously cannot be adapted to military service" may be eliminated via this regulation. The document recommending this separation must find that: (1) the medical or surgical condition is permanently incapacitating in that it is not temporary or curable within a reasonable period of time; or (2) the mental deficiency or "constitutional psychopathy" (use those words) renders the soldier inadapted to the military service; (3) the diagnosis as recorded constitutes a medical, surgical, or mental deficiency or a constitutional psychopathy (thus emphasizing that within the meaning of the regulation, neurosis is medical, and passive dependency is a constitutional psychopathy); and (4) in cases in which there might be a question of sanity (be very liberal) the patient had "the mental capacity to form the intent to desert." This is best accomplished by making the three "sanity findings" previously referred to.

AR 615-366, par. 2b authorizes administrative separation for fraudulent entry into the Army. The regulation relates to the "individual's procuring his enlistment or induction by concealment of *** a physical defect which would have made the individual ineligible for enlistment or induction." A true extract copy of NME Form 4 or SF Form 89 in cases of enlistment or induction respectively should be secured to show how the soldier answered the questions concerning his previous medical history. If a soldier who entered the service fraudulently possesses such qualifications that he is an asset to the service, the commanding general of an army in the zone of the interior may waive the right to discharge him for fraud.

If this is done, further action or cognizance of the fraudulent entry cannot be taken during the current service. Implementation is accomplished by an AR 600-450 board which finds the soldier has fraudulently entered the service, but that he possesses such qualifications that he is an asset to the service, and recommends that the right to discharge him for fraud be waived. Other pertinent recommendations such as "return to duty" are made.

AR 600-443 directs the "prompt separation of known homosexuals from the Army" as mandatory. The procedure and definitions of classes of homosexuality are specified in the regulation. AFR 35-66 is practically identical. The medical document is usually a certificate with the following findings: (1) diagnosis; (2) class of homosexuality (with a statement that the soldier is a true, confirmed, or habitual homosexual, or possesses only homosexual tendencies); (3) that the soldier did not claim uncontrollable, perverse tendencies for the purpose of avoiding further military service; (4) that the condition is not presently amenable to therapy and that further effort at rehabilitation will not make him of use to the military service; (5) (6) and (7), the three "sanity findings" because the soldier may come to trial.

AR 615-368 and AR 615-369 authorize the administrative separation of enlisted personnel because of (1) unfitness, (2) inaptitude, or (3) unsuitability generally caused by a pathologic personality, faulty attitudes, lack of motivation, unwillingness, or mental deficiency. SR 600-500-5 and AFR 160-24, state that hospitalization of such persons is usually unnecessary.

Basic Policies:

1. "Non-effectives who are not disabled are to be disposed of through non-medical channels."
2. Continued effort will be made to screen and eliminate inapt and unsuitable persons. A soldier will be discharged by AR 615-369 only when it is determined that he "cannot be developed to the extent where he may be expected to absorb further military training and/or become a satisfactory soldier."
3. "An individual who has demonstrated inaptness or unsuitability for military service, but whose psychiatric or physical condition is not such as to warrant discharge for disability, will be disposed of" under AR 615-369.
4. It is not necessary that a soldier be reduced in grade prior to his appearance before an AR 615-369 board.
5. A person will be discharged from the service by AR 615-368 only when "it is definitely established** that he cannot be rehabilitated to the extent where he may be expected to become a satisfactory soldier."
6. Persons discharged from the Army by AR 615-368 or AR 615-369 will be reentered only on authorization by the Adjutant General.

It will be noted in each regulation that a medical officer will examine and report on the soldier's mental and physical condition. Where psychiatric considerations are involved, the medical officer will be a psychiatrist and where "any doubt exists as to the existence of a mental or physical disability," the soldier will be examined by a board of medical officers. This board may be convened under AR 40-590 and

other authority as may be proper to the type of case, and its findings reported on WD AGO Form 8-118.

1. Whether or not psychiatric considerations are involved, it is believed that if a psychiatrist examines the patient, the report of the examination should be in certificate form and should contain those elements necessary for the psychiatrist's report.

2. The board report, although somewhat different in form from a certificate, contains the same elements. A timesaving effective policy is to convene a board on a patient if a lay person might feel that "doubt exists as to the existence of a mental or physical disability," e.g., on a patient referred from another station for the express purpose of making this determination prior to AR 615-368 or AR 615-369 proceedings.

It is necessary that the observations and findings outlined below be made to justify a conclusion that the soldier is (1) unfit or shows (2) inaptitude or (3) unsuitability for the service. These observations and findings as well as recommendations are the necessary elements of both certificates and boards.

1. AR 615-368 - Unfitness: In support of the finding of the soldier's unfitness it must be stated that he (a) shows certain habits or traits of character which must be named with their manifestations, (b) possesses unclean habits, (c) is guilty of repeated petty offenses, (d) is a habitual shirker, or (e) was recommended for discharge by a board of medical examiners as outlined in par. 1a(1)(e), AR 615-368 because of "psychopathic (antisocial) personality" (2), or because the board classified him as having "no disease," and his record revealed frequent disciplinary actions....and/or it is clearly evident that his complaints are unfounded and are made with the intent of avoiding service.

It is quite evident that without referral to any board, a soldier who presents unfounded complaints, repeatedly, after his being examined and returned to duty with a clear understanding that he presents no disease process incompatible with performance of assigned duty, falls into the category of the habitual shirker and that certificate to that effect is warranted at such time as it becomes evident that he is useless and non-effective and that the shirking cannot be corrected by the means available to his Commanding Officer.

Other necessary findings are that: (a) he is totally unfit for further retention in the military service, (b) his rehabilitation is considered impossible because either repeated attempts to accomplish this have failed, or attempts at rehabilitation are impractical, for reasons which must be stated, (c) "the soldier was and is mentally responsible both to distinguish right from wrong and to adhere to the right" (3), (d) "he cannot be rehabilitated to the extent where he may be expected to become a satisfactory

FOOTNOTE

(2) This provision is particularly applicable to (1) soldiers who are patients on a psychiatric service so that an expert determination can be made as to whether or not "attempts at rehabilitation are impracticable" and (2) those who although attempts at psychiatric rehabilitation can be made, no other attempts, e.g., environmental, are practicable within the hospital setting.

soldier," (3), and (e) "there are no disqualifying mental or physical defects sufficient to warrant discharge through medical channels." (3).

2. AR 615-369 - Inaptitude: A soldier will be discharged for inaptitude only when it is determined that he "does not possess the required degree of adaptability necessary for military service after reasonable attempts have been made to reclassify and reexamine him in keeping with his abilities and qualifications." In support of such a finding it must be stated that he (a) lacks the required degree of adaptability for military service, (b) lacks general fitness, (c) lacks readiness or skill, (d) is extremely unhandy or (e) is inept in some other specific way. Within the present meaning of the regulation, inaptitude is hardly a psychiatric determination, but is rather a conclusion reached by the soldier's unit commander, based on observation of his performance. Inaptitude should come into psychiatric consideration only in the event that such a conclusion has been reached and the medical officer is asked to determine whether or not there is a psychiatric basis for the already demonstrated inaptitude.

3. AR 615-369 - Unsuitability: In support of this finding it must be stated that the soldier (a) lacks physical stamina (4); (b) presents such character and behavior disorders as a schizoid, paranoid, cyclothymic, inadequate or asocial personality; or emotional instability, dependency, or aggressive immaturity reactions; (c) has a mental deficiency; (d) shows apathy, defective attitudes, and inability to expend effort; (e) has acute reactions to special stress associated with one of the personality types mentioned in (b), (c), or (d); and (f) has an immaturity reaction with enuresis or other symptomatic habit formation.

Other necessary findings are that: (a) he is unsuitable for further military service, (b) he cannot be developed to the extent where he may be expected to absorb military training and/or become a satisfactory soldier, (c) "the soldier was and is mentally responsible, both to distinguish right from wrong and to adhere to the right," (3) and (d) "there are no disqualifying mental or physical defects sufficient to warrant discharge through medical channels." (3)

In certain persons there is a combination of mental or physical disability and unfitness, inaptitude, or unsuitability. Such combined cases are disposed of by first determining whether or not the soldier is unfitted for military service by reason of physical or mental disability. If he is so unsuited, he is presented to the AR 600-450 board with a view to referral to the Physical Evaluation Board. The AR 600-450 board makes a specific finding that although the unfitness, inaptitude or unsuitability exists, the presenting cause for inability to perform duty is the medical disability. If there is no medical disability but the soldier is rendered non-effective by reason of unfitness, inaptitude, or unsuitability, he will be referred to a board of officers convened under the proper regulation with a view to administrative discharge. Persons who are unfit because of personality deviation, poor motivation, or unwillingness are separated for these causes notwithstanding the presence of a nondisabling medical or surgical condition when maximum benefit from hospitalization for such a condition has been attained.

AR 345-415, par. 9 authorizes the appointment of an investigating officer in every case of injury off the post, or when incurred under circumstances indicating willful misconduct, willful neglect, or gross negli-

gence, or when the surgeon requests investigation. Battle casualties, directly caused by enemy action, are not investigated. A certificate by the medical officer is required and must show: (1) the extent of the injuries, (2) an estimate of further possible partial or complete permanent disability, (3) a statement as to the patient's sobriety on first examination, (4) whether or not the patient was under influence of drugs, and (5) the "sanity findings" with particular regard to the injury or suicidal attempt in all cases of attempted suicide and in all other cases where mental competency is in question.

AR 605-200 provides for the elimination and demotion of officers. This regulation for officers is comparable to AR 615-368 and AR 615-369 for enlisted personnel. Depending on degree, demotion, elimination, or separation is indicated when an officer shows a decrease in efficiency, prolonged mediocrity, lack of leadership, lack of technical proficiency, or failure to discharge his assignments. Elimination is indicated when an officer is personally financially delinquent, misrepresents facts in an official document, shows habitual intemperance, recurring misconduct, or apathy, defective attitudes inability or unwillingness to expend effort, or other character and behavior disorders. A recommendation that an officer be referred to a board of officers convened under AR 605-200 may be made by a medical board or by certificate. The concepts set forth in discussing persons with a combination of mental or physical disability and unfitness, inaptitude or unsuitability are applicable. Although the procedure is not covered in any regulation, officers who are non-effective to a mild degree because of "unfitness, inadaptability or unsuitability" may present a request to a medical board for unqualified resignation of commission. The medical board may make a finding indicating cognizance of this request, and may further find that its acceptance would be to the best interests of the government and may recommend its acceptance. AR 605-275 permits an officer to submit his resignation at any time, and also permits wide discretion by the Army in acceptance of such a resignation.

The foregoing has been modified from a paper by the same title published in the June 1951 U.S. Armed Forces Medical Journal and, as pointed out, deals with inter-related regulations, some of which are not applicable in their entirety to use in the Far East Command.

In the Far East setting, certain problems present themselves. Considerable screening has been accomplished during training in the ZI so that most of the inept and unsuitable have been eliminated. There are very few soldiers arriving in this command so mentally deficient or so immature that disposition under AR 615-369 is indicated. Further, the shift from a cadre army, with the higher standards required by the cadre mission, to a functioning, fighting army where utilization of manpower becomes paramount, reduces the necessity for such disposition.

FOOTNOTES:

(3) Use these words.

(4) This applies to the group unlikely to render effective service if returned to duty, but who can be returned to civil life without recurrence of symptoms. The neuroses of these soldiers would very likely recur on return to duty, but should not recur if they are returned to their families.

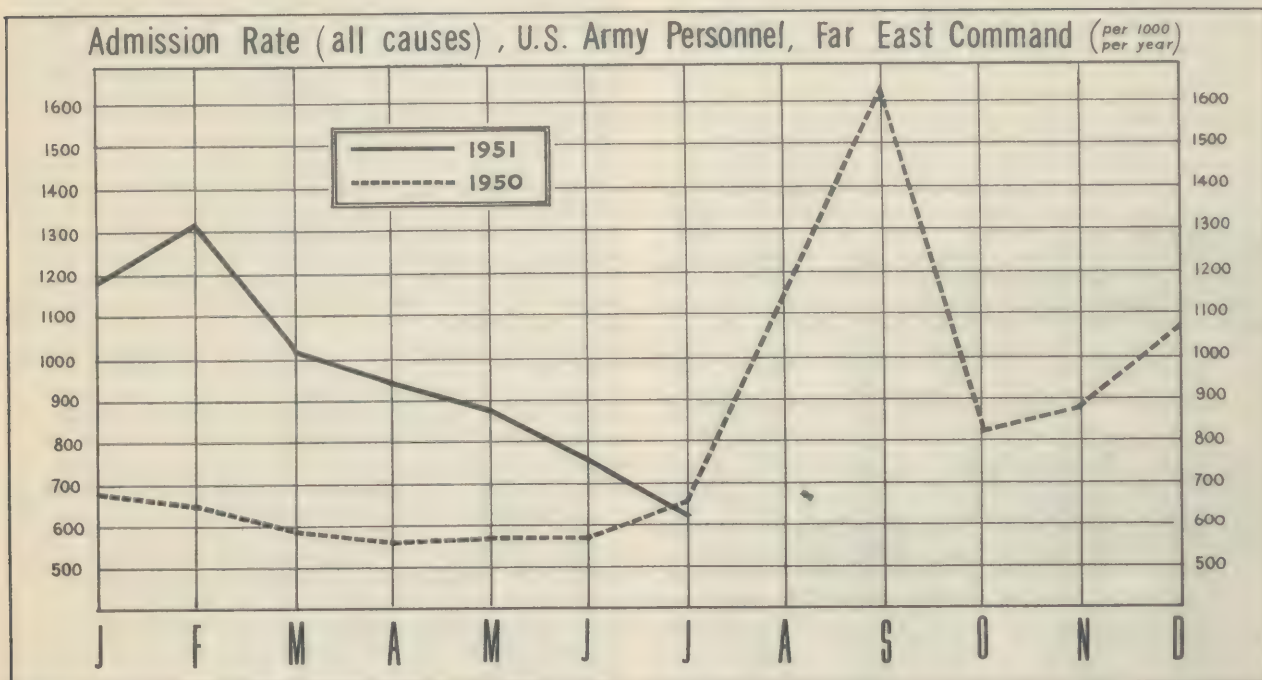
Conversely, the increase of the unpleasant and the dangerous in the life and duty of the soldier has caused the habitual skirker, the alcoholic, the drug addict and the psychopathic (antisocial) personality to stand out in bold relief from their more useful fellows. Thus elimination of the unfit under AR 615-368 becomes of greater importance.

In the handling of non-effective personnel, the regulations clearly delimit the areas of responsibility. The medical officer is charged with the determination of whether or not the soldier is medically capable of performing duty, and in what setting.

This paper deals with the proper effective presentation of expert medical opinion to command, and has stood the test of time in two wars, both at home and overseas. Although presented only as a guide, reasonably close adherence to the principles set forth is considered necessary for full effectiveness.

Action to accommodate for disease process may be taken by treatment, hospitalization, evacuation, and profile evaluation. In those, non-effective due to non-medical reasons, the medical officer is charged only with presenting the expert, medical opinion to command, and definitive disposition by army regulations, lies with command.

HEALTH OF ARMY TROOPS, FEC

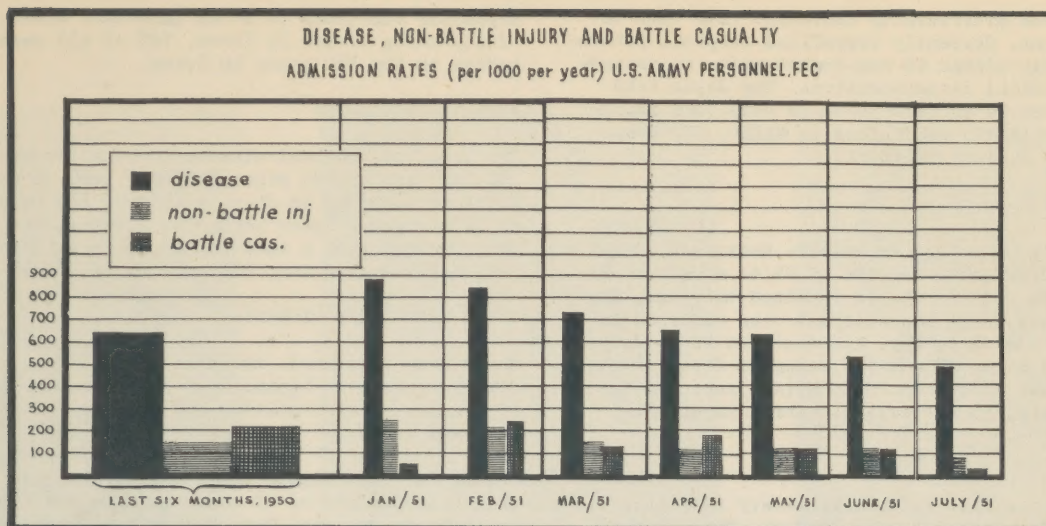


Admission rates per 1,000 troops per annum, Army personnel, for the 4-week period ending 25 July 1951 were as follows:

	FEC	JAPAN	KOREA	MARBO	PHILCOM(AF)	RYCOM
All Causes	616	460	700	278	485	561
Diseases	489	402	535	187	427	489
Injuries	95	58	114	91	58	71
Battle Casualties	32	0	50	0	0	0
Psychiatric	24	18	28	11	9.7	5.2
Common Respiratory Diseases and Flu	56	73	47	23	136	66
Primary Atypical Pneumonia	1.5	1.8	1.5	0	0	0
Bacillary Dysentery	2.1	.11	2.9	0	9.7	4.1
Amebiasis	.47	.11	.62	0	0	1.0
Malaria, new	23	35	18	0	39	5.2
Infectious Hepatitis	9.7	6.0	12	11	0	9.3
Dermatophytosis	6.4	5.0	6.5	11	0	17
Rheumatic Fever	.58	.91	.39	0	0	1.0
Venereal Diseases	181	169	189	23	19	179

DAILY NON-EFFECTIVE RATE

All Causes	25	56	11	7.7	56	15
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ALL CAUSES ADMISSION RATE:

The admission rate for Army personnel to medical treatment facilities and quarters for all causes in the FEC decreased to a rate of 616 per 1,000 strength per year in July from a rate of 755 in June. A steady decrease has been reflected in the all causes admission rate since January 1951. The greatest contributing factor in the decline of the all causes admission rate is the decrease in battle casualty rates.

For the last six months the reported admissions for disease among Army personnel in the FEC had steadily decreased to the rate of 489 for July. The rate for July 1950 was 414. An insignificant increase occurred in PHILCOM (AF). The greatest decrease in disease rates was experienced in Korea and MARBO. Among the reportable diseases, an increase was reported in venereal disease both in Japan and Korea. A slight increase in dysentery was also noted, principally in Korea. The rates for measles, German measles, mumps and infectious hepatitis continue to decrease. The malaria rate was slightly lower than the June rate.

A minor decrease is reflected in the FEC nonbattle injury component of the all causes rate. The rate for Army personnel in July is 95 as compared to 112 for June. The greatest decrease for nonbattle injuries occurred in Korea, with a rate of 114 for July as compared to 137 for June. An increase in nonbattle injuries is reported in RYCOM.

The battle casualty admission rate for the FEC decreased from 111 in June to a rate of 32 in July. This is the lowest reported rate for battle casualties since hostilities began in Korea. The July battle casualty rate for Korea only is 50 as compared to 172 in June.

DAILY NON-EFFECTIVE RATE:

The daily non-effective rate for the FEC continued to decrease to a rate of 25 for July. The June rate was 34. RYCOM and PHILCOM (AF) rates were static; the MARBO rate slightly lower. The Japan rate for July is 56 as compared to 81 for June.

DISEASES:

DISEASES OF THE CENTRAL NERVOUS SYSTEM:

There were 11 new cases of poliomyelitis reported in the FEC for July. This brings the total reported cases to 36 for the first seven months of 1951. One death occurred. Six of the new cases were among Army personnel, 4 of them from Japan and 2 from Korea. One case was of Navy personnel in Japan and one case from the Coast Guard in PHILCOM (AF). Of the other 3 cases one occurred in a dependent of military personnel, 1 was DAC personnel and the other a dependent of DAC personnel.

During July, 15 cases of clinically diagnosed encephalitis were reported, making the total of 44 cases for the first seven months of 1951. There were no deaths. Of the 15 cases, 8 were Army personnel, 6 from RYCOM, 1 from Japan and 1 from Korea. Four Air Force cases and 1 Navy case came from RYCOM, two civilian cases in RYCOM, one a DAC, the other a dependent of military personnel. None of the cases reported thus far have been confirmed as Japanese "B" type of encephalitis.

Seven new cases of meningitis of various types were reported in July. This brings the total to 24 cases, with no deaths, for the first seven months of 1951. Five meningitis cases reported for July originated in Japan and 2 in Korea. Three cases were US Army personnel, 3 were dependents of military personnel and one case occurred in DAC personnel.

The above data on diseases of the central nervous system are obtained from Special Telegraphic Reports of Epidemic Diseases (MED-16) and include all clinically diagnosed cases.

PSYCHIATRIC:

The incidence of psychiatric conditions reflected a definite decrease in the FEC from the high rate of 44 in June to a rate of 24 for July. The most notable decrease was reported from Korea with a July rate of 28 as compared to 56 in June. This is the lowest rate since January when the rate was 27. The lessened psychiatric rate in Korea for July is partly a result of a correction in assignment policy. The practice of assigning reprofiled hospital returnees to duty with their original combat unit was largely discontinued in July. This prevented the multiple hospitalization

and subsequent artificially increased rate that occurred in June. Currently reprofiled hospital returnees are mainly placed in non-combat units in accordance with medical recommendations. The Japan rate decreased from 24 in June to 18 in July. The incidence of psychiatric conditions in MARBO, RYCOM and PHILCOM (AF) is insignificant.

MALARIA:

The incidence rate for new malaria decreased slightly in the FEC from the June rate of 25 to a rate of 23 for July. The rate for Korea remained the same, 18. The Japan rate where the sharpest rise occurred in June to 42 from 19 in May, decreased to 35 in July. The great majority of malaria cases in Japan originated in Korea. RYCOM and PHILCOM (AF) reported decreases. Again, no new cases occurred in MARBO.

DYSENTERY:

In the FEC, the rate for all dysentery increased to 12 in July from the 9.4 rate in June. The majority of cases are reported in Korea where the rate rose from 13 in June to 18 in July. Both Japan and RYCOM reported only 5 cases, and PHILCOM (AF) one case. Again no cases were reported from MARBO. Parallel to the dysentery rates for the command is the occurrence of bacterial food poisoning. Of the 144 cases reported, 142 occurred in Korea, 2 in Japan, and no cases in the other commands.

INFECTIOUS HEPATITIS:

The incidence of infectious hepatitis in the FEC reflected a slight decrease in July. An increase was experienced in MARBO and a slight decrease in RYCOM. Again no cases were reported from PHILCOM (AF). The Japan and Korea rates remained static. Infectious

HOSPITALIZATION:

The bed status as of 25 July 1951 was as follows: (These data cover all patients, Army, Air Force and others.)

	Designated Beds	Operating Beds	Average Beds Occupd.	% Designated Beds Occupd.	% Operating Beds Occupd.
JAPAN	8,250*	10,250	6,899	84	67
KOREA	4,700	5,379	2,084	44	39
MARBO	200	390	47	24	12
PHILCOM (AF)	100	116	84	84	72
RYCOM	400	388	275	69	71
FEC	13,650	16,523	9,389	69	57

In Korea, there were 11,750 POW operating beds, 9,173 of which were occupied.

(* Does not include 2,000 TD beds.)

EVACUATION:

Tabulated below is the number of patients (all types of personnel) evacuated from the major commands to the ZI during the four report weeks in July and the number of patients awaiting evacuation as of 27 July 1951:

	JAPAN	MARBO	PHILCOM (AF)	RYCOM	FEC
By Air	1,517	2	12	72	1,603
By Water	9	0	2	3	14
Total	1,526*	2	14	75	1,617
Patients Awaiting Evacuation	140	0	0	42	182

(* 1,181 patients originated from Korea)

hepatitis continues to be an important cause of morbidity among troops in Korea. 76% of all cases reported in the FEC occur in Korea.

VENEREAL DISEASES:

The trend of venereal disease in Army troops for the FEC has been upward since December 1950. A noticeable increase occurred in July, a rate of 181 as compared to 150 in June; Korea being the greatest factor in the increase with a rate of 189 in July. The RYCOM rate was lessened from 211 in June to 179 in July.

OTHER REPORTABLE DISEASES:

Among Army personnel, no cases of smallpox, scarlet fever, typhoid or typhus were reported. The incidence of measles, German measles and mumps continues a downward trend.

During July the Eighth Army in Korea received reports of the occurrence of 66 cases of an acute febrile hemorrhagic disease. This brings the reported occurrences of this syndrome to approximately 75 since early June. The specific diagnosis of this disease has not yet been determined but it is now believed that leptospirosis, the original diagnosis, has been ruled out. Clinical, laboratory and epidemiological investigations are being conducted in an effort to define the disease more accurately and to determine its etiology and method of transmission.

DEATHS:

There were 49 deaths due to all causes reported by all medical treatment facilities in the FEC in July. Thirteen deaths were due to disease, 19 to nonbattle injury and 17 to battle casualties. Forty-two deaths occurred in Korea and 7 in Japan.

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Brig Gen. Parma is congratulated by Brig Gen. Man, Chief of KMAG, as 60th Indian Ambulance Corps receives unit commendation.



Col. Rolf Kaijser, C. O. of Swedish Red Cross Hospital. Unit completed first year in Korea on 23 September.



Members of 52nd Med Bn remove patient from combination rail-highway bus-ambulance at RTO, Pusan, Korea.



Aged Korean couple are prepared for evacuation to rear by 25th Div CAS.



Dr. Gustafsson, Dental Officer of Swedish R. C. Hospital examines patient.



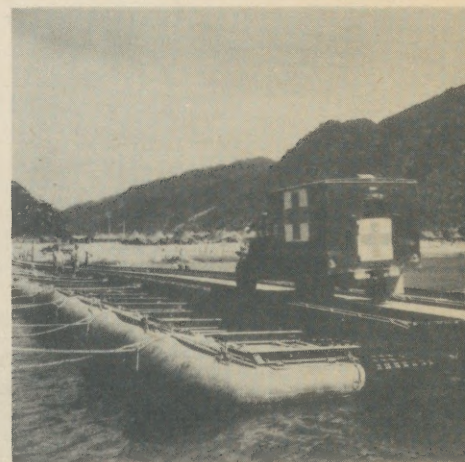
Wounded soldier of 18th Regt, 8th ROK Div., is treated at Battalion Aid Sta.



Island nurses who arrived during month visit with countrymen at Tokyo Army Hosp.



A nurse of UNCACK team gives inoculations to residents of Korean town.



Ambulance of 568th Med Amb Co crosses pontoon bridge over Soyang River.

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The Chief Surgeon extends an invitation to all Far East Command medical personnel of the U. S. Army, Navy and Air Force, or of the United Nations, to prepare and forward with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted unless author states otherwise.

Lt. John J. Griffin, Editor

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